

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF VIRGINIA  
ABINGDON DIVISION

UNITED STATES OF AMERICA, )  
)  
Plaintiff, ) Criminal Case No.  
) 1:17-cr-00027-JPJ-PMS-1  
vs. )  
)  
JOEL A. SMITHERS, )  
)  
Defendant. )

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**REDACTED** TRANSCRIPT OF JURY TRIAL - DAY 7  
HONORABLE JUDGE JAMES P. JONES PRESIDING  
TUESDAY, MAY 7, 2019

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**A P P E A R A N C E S**

On behalf of United States:  
**Steven Randall Ramseyer**  
**Zachary T. Lee**  
**Samuel Cagle Juhan**  
United States Attorneys Office  
180 West Main Street, Suite B19  
Abingdon, VA 24210

On behalf of Defendant:  
**Donald M. Williams, Jr.**  
Williams Law Office, PLC  
P.O. Box 601  
Pennington Gap, VA 24277

Proceedings taken by Certified Court Reporter and transcribed  
using Computer-Aided Transcription

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1 (Proceedings commenced at 9:00 a.m.)

2 THE COURT: Good morning, ladies and gentlemen.

3 Mr. Williams, are we ready to proceed?

4 MR. WILLIAMS: Your Honor, I think if we might, if  
5 we could take up a couple of matters first, I think it could  
6 have an impact on my client's decision to testify.

7 THE COURT: All right. If you would come to the  
8 lectern, please.

9 MR. WILLIAMS: Your Honor, the -- I think the first  
10 matter that I would say that I would ask to address would be,  
11 we had filed a motion regarding a Motion to Suppress, asking  
12 that the Government not be allowed to go into certain  
13 information regarding Dr. Smithers's enrollment in a Health  
14 Professional Monitoring Program. I think at the initial  
15 outset the Government kind of indicated that they may not --  
16 unless the defendant intended to testify, that they probably  
17 wouldn't pursue something like that. I think that certainly  
18 my client now would request a ruling on that.

19 It's our position that back when he was trying to  
20 get his license in Virginia, one of the -- the allegations are  
21 that he had to sign up on this health care -- Health Care  
22 Professions Monitoring Program, HPMP. What it was was that I  
23 think the Government intended to introduce an e-mail that was  
24 from a Dr. Harp stating that he wanted Dr. Smithers to sign up  
25 on this program.

1           The allegation is that Dr. Smithers did sign up on  
2     the program. There's a document that he signed stating under  
3     that that he was -- that he agreed not to see, I think it was,  
4     any patients or anything during the time until he was cleared  
5     through HPMP.

6           He began -- it was about -- I think his testimony  
7     would be he didn't understand that part of it. He began to  
8     see patients. He had already had his license established.  
9     The license was never revoked. Our position is HPMP doesn't  
10    have the authority to be able to suspend the license. He had  
11    a valid license. The license was never revoked. He was never  
12    disciplined or anything underneath that. We believe under  
13    Rule 403 it would be highly prejudicial to introduce this  
14    evidence and far more prejudicial than probative. We believe  
15    that certainly that evidence should be suppressed and that the  
16    Government should not be allowed to impeach or cross-examine  
17    or anything with respect to that. So that would be the nature  
18    of our motion.

19           THE COURT: All right. Was there some other  
20    aspect -- some other question about that that you wanted the  
21    Court to rule on?

22           MR. WILLIAMS: I think that was the main one,  
23    Your Honor. I believe that -- certainly, I think there was  
24    also -- we also had introduced to the Government -- I  
25    apologize, Your Honor.

1           We had provided to the Government -- the Court had  
2 admitted Defendant's Exhibit 1, which was an article through  
3 the expert. We also have just the -- underneath the article,  
4 there were certain little tabs that you could click on that  
5 explained more information regarding the article.

6           At this time we would just ask for that to be  
7 introduced as part of Exhibit 1, whether it be Exhibit 1-A or  
8 Exhibit 1 that we would be asking for admission. It is simply  
9 a tab under Exhibit 1 that we think more fully explains what  
10 Exhibit 1 is.

11           THE COURT: All right. Well, have you shown that to  
12 the Government?

13           MR. WILLIAMS: We have. We provided them a copy,  
14 Your Honor.

15           THE COURT: All right. So that's --

16           MR. WILLIAMS: Those are the two main things I think  
17 that we had.

18           THE COURT: All right. Well, let me hear from the  
19 Government.

20           MR. RAMSEYER: Your Honor, as to Defendant's  
21 Exhibit 1-A, which is what he's called it, it is the tabs --  
22 it's represented to be tabs from an internet site. There's no  
23 evidence that Dr. Smithers ever saw this or that it guided his  
24 practice in any way. So we're not really sure of the  
25 relevance of it. It's -- and it's not really -- it really has

1 no relevance to the case anyway. It says, "Warns about  
2 serious risks or death when combining opioid pain or cough  
3 medicine and benzodiazepines."

4 And I'm not sure what that's for. But the Court  
5 hasn't seen it, so I'd give it to the clerk to look at it.

6 THE COURT: Maybe I could see Exhibit 1, Defendant's  
7 Exhibit 1, too, Madam Clerk.

8 All right. And the other questions?

9 MR. RAMSEYER: Your Honor, as to the HPMP material,  
10 so background, Dr. Smithers, when he was in North Carolina  
11 doing his residency, I guess, or internship, became subject to  
12 North Carolina's Monitoring Program for physicians who may  
13 have impairment issues. And so when he applied -- and then he  
14 went and practiced in West Virginia. When he applied for a  
15 license in Virginia, Virginia said we will only do that --  
16 we'll only give you a license if you participate in Virginia's  
17 HPMP program.

18 So he signed up with the HPMP program and signed a  
19 contract with the HPMP program on August 11th of 2015. And in  
20 that contract he agreed that he would refrain from practicing  
21 or working in Virginia in any position in a healthcare setting  
22 until approved by HPMP staff. And he signed that on  
23 August 11, and he's practicing immediately without any  
24 approval from the HPMP people. He did not receive approval.  
25 That goes on for several months. And then at some point, I

1 believe in November, he's terminated from the program because  
2 he didn't comply. So we think it's --

3 THE COURT: Let me ask you the -- what does HPMP  
4 stand for?

5 MR. RAMSEYER: It is Health Practitioners'  
6 Monitoring Program.

7 THE COURT: And what was -- you said he had a -- I  
8 mean, what was the monitoring program about? What was the  
9 disability that --

10 MR. RAMSEYER: It says under -- under the  
11 participation contract, it says, "I, Joel Smithers,  
12 recognizing that I may suffer from the disease of alcoholism,  
13 and/or chemical dependency, and/or mental illness, and/or  
14 physical illness that impairs my ability to practice my health  
15 profession safely, as evidenced by my history of monitoring  
16 with the North Carolina Physician Health Monitoring Program."

17 THE COURT: Well, do we know what, in fact, was the  
18 nature of his disability -- I mean, that chemical dependency?  
19 I mean, it was abusing drugs, or...

20 MR. RAMSEYER: Your Honor, it's unclear from the  
21 records as to what it is.

22 THE COURT: So what is the relevancy of all of this?

23 MR. RAMSEYER: Well, we believe it goes to his  
24 truthfulness, if he testifies. I mean, we don't intend to  
25 introduce this if he's not a witness. But as to his

1 credibility, we believe it's relevant that he tells the person  
2 from the Board of Medicine, you know, I'll sign up for the  
3 HPMP program. I'll do that. And, in exchange, Virginia gives  
4 him a license and immediately he's in violation of the  
5 contract with the HPMP that says he will not participate -- he  
6 won't see patients. I mean, it's right away. It's not like  
7 it's two months later. I mean, it certainly appears to the  
8 Government he perpetrated a fraud upon the Virginia Board of  
9 Medicine to get a license, that he had no intent to comply  
10 with the program.

11 THE COURT: Well, so it shows his untruthfulness?

12 MR. RAMSEYER: Yes, Your Honor.

13 THE COURT: All right. I guess the problem, as  
14 Mr. Williams relies on, is Rule 403. I mean, aren't we going  
15 to have to get into what was going on here? If it's -- if we  
16 don't, then the jury is going to believe that he was  
17 disciplined for what he allegedly did in this case over  
18 prescription of narcotics, which is not true. And then so we  
19 have to get into, you know, that he has alcohol or drug  
20 problems. And that's -- you know, that's not really relevant  
21 to any of the evidence that we've heard. I mean, he's not  
22 been -- well, I mean, it's -- I don't see any connection in  
23 the evidence and his possible addiction to alcohol or drugs.  
24 And, again, that seems to me that may be unfairly prejudicial  
25 to him.



1 MR. RAMSEYER: Well, Your Honor, the Government  
2 would proffer that what would happen is Dr. Smithers would  
3 testify. The Government would ask him: Isn't it true that as  
4 a condition of you getting a license in the state of Virginia  
5 you had to sign a contract that had certain conditions in it?

6 Presumably, yes.

7 And one of the conditions was that you not practice  
8 medicine until you'd received approval from a program of  
9 Virginia?

10 Yes.

11 And didn't you, in fact, immediately start  
12 practicing medicine?

13 Yes.

14 Didn't you, in fact, lie to the Board of Medicine  
15 when you said you were going to participate in this program?

16 And we don't think that would unfairly prejudice the  
17 defendant. It shows that he lies. It doesn't really open the  
18 door to anything else.

19 Obviously, if he testifies on direct to certain  
20 things about that he's a clean guy, he's never had any  
21 problems, then we think those things would be relevant. But  
22 assuming he doesn't do that, we think these questions would be  
23 appropriate.

24 THE COURT: All right. Anything else?

25 MR. RAMSEYER: No, Your Honor.

1 THE COURT: Okay. Mr. Williams, what about that?  
2 What about if we don't get into any of the -- simply that he  
3 signed an agreement, apparently, that says he couldn't  
4 practice until he got permission in Virginia? But that he  
5 did, in fact, do that. He can say, well, I didn't understand  
6 that, or I didn't read that part or something like that.

7 MR. WILLIAMS: May I have one second?

8 THE COURT: Yes, sir.

9 MR. WILLIAMS: Your Honor, I think, certainly, my  
10 client wanted to say the reason he was in the program was he  
11 had a diagnosis of depression and anxiety. I think he wanted  
12 to make sure that was clear with what the -- North Carolina  
13 had said what he was being treated for. With respect to this,  
14 I think certainly our position is that to go into this, HPMP  
15 had no authority to suspend his license. It is simply a -- I  
16 think -- I don't think it's a for-profit entity that just  
17 reports to the Department of Health Professions. And,  
18 actually, it's the Department of Health Professions that  
19 actually has to suspend the license.

20 We simply believe that, again, the prejudicial  
21 nature of this certainly outweighs whatever probative value  
22 there would be. I think it causes confusion within the jury,  
23 makes them begin to believe that he potentially has  
24 abusive-type things, whether it's drugs or whatever. I know  
25 that there's the allegation of -- or the charge of possess

1 with intent to distribute where he has the backpack and  
2 everything. And certainly, it causes us concern with respect  
3 to that that a jury is hearing that, you know, there are abuse  
4 -type situations with that, so...

5 THE COURT: Let me ask you about this attachment. I  
6 really don't understand what the purpose of this attachment  
7 is. I mean, frankly, I'm not sure that I should have admitted  
8 this Defendant's Exhibit 1 as an exhibit. It really was used  
9 in the cross-examination of you by a witness. You know, under  
10 the rules, you can do that, but the -- the pamphlet or book or  
11 other written information doesn't go into evidence.

12 But I've already admitted it. I don't think it's  
13 any -- I'm not going to reverse my decision. But this other  
14 thing, I don't understand what that has to do with anything --

15 MR. WILLIAMS: Your Honor, my client --

16 THE COURT: -- that it would help the jury in any  
17 way. I mean, it's just a more elaborate statement of  
18 Exhibit 1, which warns about risk when combining opioid pain  
19 or cough medicines with benzodiazepines, which I'm not sure  
20 what that has to do with anything. Maybe there's some  
21 argument that I don't understand there, but I --

22 MR. WILLIAMS: And I think, Judge, what our argument  
23 would be simply with respect to that is is that on the death  
24 of Heather Hartshorn, which is the -- I don't remember exactly  
25 the count number, but on the death count involving her, one of

1 the things that I think Dr. Hail testified to was that based  
2 upon information she had looked at, being the autopsy report  
3 and other things, was that Ms. Hartshorn was also -- had  
4 Benzodiazepines in her system, along with the opiate  
5 medication that was involved with what Dr. Smithers had  
6 prescribed. I think what our allegation or what our argument  
7 is is that certainly --

8 THE COURT: Well, what does this -- I mean, that's  
9 certainly what exhibit -- Defendant's Exhibit 1 says. And  
10 what does this additional exhibit say in that regard?

11 MR. WILLIAMS: Your Honor, my client basically  
12 handed me that this morning. I think these were just simply  
13 the tabs. Our position would be that it certainly helps  
14 explain and answer. It goes into more detail about the basis  
15 of the conclusions. I think --

16 THE COURT: I've looked at it. I don't believe --  
17 again, we've got enough exhibits here. I believe that the  
18 point is made in the original Exhibit 1, which I don't think  
19 that the expert contested, as I recall.

20 So I'm going to refuse the -- why don't we mark this  
21 as Defendant's Exhibit 2.

22 MR. WILLIAMS: Okay.

23 THE COURT: And refused.

24 And, Madam Clerk, if you'll do that and, of course,  
25 separate that.

1 And here's back Defendant's Exhibit 1, which is  
2 admitted -- which has been admitted.

3 All right. Anything else you want to say?

4 MR. WILLIAMS: No. That would be all.

5 THE COURT: All right. I'm going to grant the  
6 defendant's motion under Rule of Evidence 403. While I  
7 recognize that the Government does not intend to get into the  
8 details of this, I think either way it is unduly prejudicial  
9 to the defendant to get into the HPMP contract and his alleged  
10 violation of that contract.

11 You know, while it may have a connection to his  
12 truthfulness if he testifies, I just don't see how it could  
13 not help but bring up prejudicial -- unduly prejudicial issues  
14 about his mental health or speculation about other similar  
15 conduct that's not been introduced in regard to illegal  
16 distribution of narcotics. So I'm going to grant the  
17 defendant's motion.

18 MR. RAMSEYER: Your Honor, if I may. There's one  
19 matter related to that that I want to bring to the Court's  
20 attention. As part of that, at some point Dr. Smithers sent a  
21 description of his practice to the HPMP that describes it as a  
22 holistic practice, really didn't mention anything about  
23 controlled substances in it. We would just ask that the Court  
24 would consider if he testifies, depending how he testifies,  
25 the Court would potentially allow us to cross-examine him on

1 that letter. We could just say that he sent a letter to  
2 someone describing his practice.

3 THE COURT: Right.

4 All right. Mr. Williams, any objection?

5 MR. WILLIAMS: I'm not sure I completely understand.  
6 That was involved with the HPMP?

7 THE COURT: Well, why don't you look at me while  
8 you're talking at least.

9 MR. WILLIAMS: If it's involved with the HPMP,  
10 Judge, it certainly causes -- it's still going to be  
11 wondering, I think put in the jury's mind what is HPMP.

12 THE COURT: I don't know what it says, but  
13 Mr. Ramseyer represented it just to be sort of a resume of his  
14 practice. And I don't think -- doesn't sound to me like that  
15 that would be unduly prejudicial. And it may be relevant in  
16 that he does not describe himself as a pain medication  
17 practice -- I mean, a pain -- excuse me -- pain management  
18 practice which is what I understand his defense really in this  
19 case is; that he was engaged in pain management, and that's  
20 why he prescribed all of these narcotic drugs.

21 MR. WILLIAMS: And that's correct, Judge. I think  
22 certainly if this involves anything with the HPMP we would be  
23 objecting on the grounds that I think it's going to call into  
24 question of the jury, what is HPMP? If it does not, then I  
25 don't necessarily know that I have the same argument with

1 respect to it, but --

2 THE COURT: Well, let me see. Does the Government  
3 have a copy of it?

4 MR. RAMSEYER: Yes, Your Honor.

5 Your Honor, what we would be asking about would be  
6 that first paragraph.

7 THE COURT: All right.

8 MR. WILLIAMS: Your Honor, the only thing I would  
9 say, there's no date or time. We don't have any time stamp or  
10 anything.

11 THE COURT: Well, I mean, it would have to be  
12 authenticated by the -- I mean, if the defendant denies  
13 this -- if he testifies and denies that this is -- he had  
14 anything to do with this, it's just made up, I've never seen  
15 this before, something like that, that's one question. But,  
16 otherwise, I don't see anything unduly prejudicial about this.  
17 And it is relevant, seems to me, to the issues in the case.

18 MR. WILLIAMS: All right. Thank you.

19 THE COURT: So, Madam Clerk, if you'll give that  
20 back to Mr. Ramseyer.

21 All right. Is there anything further then? And you  
22 have witnesses that you're going to call?

23 MR. WILLIAMS: I have one witness and then  
24 potentially Dr. Smithers. He had indicated earlier he had  
25 something he wanted to address to the Court. I don't know if

1 he still does or not.

2 THE COURT: All right. Well, Mr. Smithers, if you  
3 wouldn't mind standing, let me advise you in regard to whether  
4 or not you intend to testify on your own behalf.

5 You have a right to remain silent under the  
6 constitution, and that means that you do not have to testify.  
7 And if you don't testify, I will instruct the jury, as I've  
8 already indicated to the jury panel, but I will instruct the  
9 jury in more detail that they are not to consider that fact at  
10 all because the Government has the burden of proof in this  
11 case, and you don't have to prove your innocence. So I will  
12 instruct the jury that they are not to consider the fact that  
13 you did not testify in reaching a verdict in this case.

14 Now, you ought to consider the advice of your  
15 counsel in deciding whether or not to testify, but that is  
16 entirely up to you. I mean, that is a decision that you must  
17 make. In other words, your attorney cannot prevent you or  
18 require you to testify. That's -- even though he may give you  
19 advice, and I expect he has or will so advise you what his  
20 opinion is. And, certainly, if you ask him, he will. But --  
21 and you ought to consider that advice, but whether or not you  
22 decide to testify is your decision. Of course, you understand  
23 that if you do testify, you will be subject to  
24 cross-examination by the Government attorney with respect to  
25 your testimony.



1           So you don't have to tell me right now. As I  
2 understand it, there is another witness who is going to  
3 testify. But, before you testify, you obviously need to make  
4 that decision whether or not you wish to testify.

5           So do you understand what I've told you, Mr. --  
6 Dr. Smithers?

7           THE DEFENDANT: Yes, Your Honor.

8           THE COURT: All right. Is there anything else you  
9 want to say to me about that?

10          THE DEFENDANT: Your Honor, I have discussed with my  
11 counsel in regards to my testimony, and because of the change  
12 of schedule, I don't really feel that that decision -- I'm  
13 adequately prepared today to testify. I would like to testify  
14 at this point, but I don't feel that I'm prepared to testify  
15 today.

16          THE COURT: Well, in what way are you not prepared?

17          THE DEFENDANT: I believe the organization of the  
18 initial direct examination with my counsel, we've yet to go  
19 all the way through that. And this decision was up in the air  
20 even into the early hours of this morning in my mind. And  
21 until late Friday evening, you know, our understanding I was  
22 going to at least have the benefit of seeing the other  
23 witnesses. And at this point we would be calling, I believe,  
24 at least two other witnesses after I testify. And I -- you  
25 know, I was hoping to testify last, if I did.

1 But it is currently my intention to testify.

2 THE COURT: You do wish to testify?

3 THE DEFENDANT: Yes, sir.

4 THE COURT: All right. Well, I don't understand  
5 about two other -- you were hoping to testify last. I mean,  
6 as I understand, there's one witness that's going to testify  
7 and then you're up. So do you understand that?

8 THE DEFENDANT: Yes, Your Honor.

9 Due to the scheduling situation, the other two  
10 witnesses would have testified before me, and they can't be  
11 here until tomorrow. And that was the reason. That changed  
12 the order of -- and the timeline of my preparation.

13 THE COURT: All right.

14 Well, Mr. Williams, tell me about that. What  
15 witnesses can't be here?

16 Yes, sir. You may be seated, Dr. Smithers.

17 THE DEFENDANT: Thank you.

18 MR. WILLIAMS: Your Honor, I think one of the  
19 witnesses was Ms. Moore, who we brought up yesterday. We were  
20 not able to get ahold of her as of yet. This was the lady who  
21 was the elder lady who had fallen that was on her way up from  
22 Florida, was supposed to have a flight last night and land in  
23 West Virginia. I think that's one of the witnesses that he's  
24 talking about.

25 THE COURT: And she, apparently -- you don't know

1 where she is or anything like that?

2 MR. WILLIAMS: I do not at this point.

3 THE COURT: And she was not subpoenaed?

4 MR. WILLIAMS: She was not subpoenaed.

5 THE COURT: Okay.

6 MR. WILLIAMS: And then I think that Dr. Smithers  
7 gave me -- he had given me a list of about 40 to 50 names of  
8 people that he wanted me to talk to that was about probably  
9 three or four days before trial. I was in the middle of trial  
10 prep, couldn't take the time out to call 40 to 50 people. But  
11 I think he was in contact with one other person about possibly  
12 testifying. I'm not even sure that I know the name of that  
13 gentleman, but --

14 THE COURT: Well, he said that there were two other  
15 people who were going to testify tomorrow.

16 MR. WILLIAMS: I think one is the gentleman he  
17 talked about, and the other one was Deborah Moore, to be  
18 hopeful that Deborah Moore would be able to be here tomorrow.  
19 That was the two that he mentioned.

20 THE COURT: But we don't know of that?

21 MR. WILLIAMS: We don't know anything about Deborah  
22 Moore at this point.

23 THE COURT: Yeah. And the other person -- you  
24 mentioned yesterday something about pharmacists. Is this a  
25 pharmacist?

1 MR. WILLIAMS: The pharmacist is here today. That's  
2 going to be the one that testifies here in just a moment. The  
3 pharmacist is here.

4 THE COURT: What about this other witness?

5 MR. WILLIAMS: The other witness is simply a patient  
6 of Dr. Smithers, is my understanding, that he treated during  
7 the course of his practice.

8 THE COURT: And that person has not been subpoenaed?

9 MR. WILLIAMS: They have not.

10 THE COURT: But -- and have you talked to that  
11 person?

12 MR. WILLIAMS: I have not, Your Honor.

13 THE COURT: All right.

14 So, you don't know -- I mean, has your -- I'm not  
15 asking you to tell me what your client said, obviously, but  
16 have you discussed what the testimony might be?

17 MR. WILLIAMS: My understanding, Judge, is that the  
18 testimony would simply be that regarding his care and  
19 treatment of the patient and kind of the visits, how it went,  
20 his practice. I think it would probably go toward the --

21 THE COURT: Similar to the other patients that have  
22 testified?

23 MR. WILLIAMS: Similar to Mr. Hartshorn and to  
24 Brenda Fisher would be my understanding, Judge.

25 THE COURT: All right. Well, I think we ought to go

1 ahead and proceed in the fashion that you've outlined. And  
2 you're going to call a witness and then Dr. Smithers. We'll  
3 take a short recess after your witness, and Dr. Smithers can,  
4 at that time, make a final decision as to whether he wishes to  
5 testify based on what advice you've given him and my advice to  
6 him.

7 He's indicated to me, as you've heard, that he does  
8 intend to testify. But I want to give him any opportunity to  
9 make that decision. Again, if you have any further advice to  
10 him, obviously, I assume you would give it to him.

11 MR. WILLIAMS: Yes, Your Honor.

12 THE COURT: All right. So we're going to hear your  
13 witness, so we'll have the jury in.

14 (Proceedings held in the presence of the jury.)

15 THE COURT: All right. Good morning, ladies and  
16 gentlemen. We're ready to go again.

17 And, Mr. Williams, you may call your next witness.

18 MR. WILLIAMS: Defense calls Tom Hayes.

19 THE COURT: Yes, sir. If you'd come up here and  
20 stand before the clerk and be sworn, please.

21 THE WITNESS: Up here?

22 THE COURT: Yes, sir.

23 THE CLERK: Please raise your right hand.

24 Do you solemnly swear that the testimony you're  
25 about to give in this case shall be the truth, the whole

1 truth, and nothing but the truth, so help you God?

2 THE WITNESS: I do.

3 THE CLERK: You may be seated.

4 THE WITNESS: Over here?

5 THE CLERK: Yes.

6 **TOM HAYES,**

7 Called as a witness herein by the Defense, having been first  
8 duly sworn, was examined and testified as follows:

9 **DIRECT EXAMINATION**

10 BY MR. WILLIAMS:

11 Q. Good morning.

12 A. Morning.

13 Q. Would you state your full name for the record.

14 A. I'm Tom Hayes.

15 Q. Okay. And spell your last name, if you would.

16 A. H-a-y-e-s. I'm the pharmacist and owner of Hayes Drug.

17 Q. And where do you live, Tom?

18 A. In [REDACTED] in Tazewell, Virginia.

19 THE COURT: Sir, just your community, we don't need  
20 your exact address.

21 THE WITNESS: Thompson Valley, Tazewell Virginia.

22 BY MR. WILLIAMS:

23 Q. And I think you said you're the owner of Hayes Drug; is  
24 that correct?

25 A. Yes, sir.

1 Q. And you own that?

2 A. Yes, sir.

3 Q. And how long have you owned Hayes Drug?

4 A. I opened it in 2008.

5 Q. Okay.

6 A. About 11 years.

7 Q. All right. Now, you said you're a pharmacist?

8 A. Yes, sir.

9 Q. Okay. Where did you get your training?

10 A. Medical College of Virginia. I graduated in '93.

11 Q. Okay. And so you got what -- what kind of a degree would  
12 that be?

13 A. It was -- at that point in time the pharmacy degree  
14 was -- it was like a BS. It was before they changed it to  
15 doctorate.

16 Q. Okay. And so -- but you are a licensed pharmacist in the  
17 commonwealth of Virginia; is that correct?

18 A. Yes, sir.

19 Q. Okay. And prior to opening -- did you work anywhere  
20 prior to opening your own drugstore?

21 A. Yes, sir. I worked full time for Kmart for about four  
22 years and averaged about 21 hours overtime, worked in probably  
23 65 stores in the first three years I was there doing overtime.  
24 I worked overtime the next, like, ten years. I think I  
25 counted up in the first 6 years I had worked in over 65

1 different pharmacies and full-time at one of my pharmacies  
2 trying to pay the bills.

3 Q. Now, when you say you're working that many pharmacies, I  
4 assume you're floating?

5 A. I would float, but I kept a full-time position at my  
6 pharmacy where I worked. Kmart had 12-hour shifts. I could  
7 work 77 hours in a week.

8 Q. All right. Now, have you had any further training or  
9 anything since you got your degree? Do you have to have  
10 continuing education, anything like that?

11 A. We do have to have continuing education. What I tend to  
12 do and what I've done is I was blessed that initially with  
13 Kmart, you do it in books. But I worked for Counts Drug for  
14 about eight years. They had three pharmacies, and part of the  
15 benefits would be that they would pay for continuing education  
16 for you to go to a professional organization like the National  
17 Association of Retail Drugstore, Virginia Pharmacist  
18 Association, and attend the live CE, which I've tried to  
19 continue to do with the VPHA, because the Virginia Board of  
20 Pharmacy has an actual presentation with the updates on the  
21 laws, which is very educational and beneficial, and so I've  
22 tried to do that most years.

23 Q. Okay. Now -- and you may have already said this, I think  
24 I missed it, but how long have you been a pharmacist?

25 A. Since 1993.



1 Q. Twenty-five years, roughly?

2 A. A little over.

3 Q. Is that pretty close?

4 A. Yes, sir.

5 Q. Okay. Now, do you know Dr. Smithers?

6 A. I'm familiar with him. I've spoke with him on the phone.  
7 I don't know for sure if I'd recognize him if I saw him, but  
8 I've communicated with him. He always made himself available.  
9 Because initially when I got his patients, I had questions, so  
10 I called him.

11 Q. Okay. And how many of his patients were regulars at your  
12 pharmacy? Do you know? I'm not asking an exact number, just  
13 approximately.

14 A. I would guesstimate between 6 and 12, something of that  
15 nature. I know -- you know, it probably fluctuated. He was  
16 in one office closer and then he moved further away. When he  
17 did, I called and discussed it with him. Some patients  
18 followed him when he went to Roanoke. It was less than he had  
19 initially what I had seen but still probably 6 or 12 at that  
20 point, may have been a few more when he was closer.

21 Q. Okay. Now, I think you stated you had talked to him and  
22 had some questions. What kind of questions did you have?

23 A. Well, if I have a new patient that has, you know, not a  
24 starting dose but looks like someone that's being treated for  
25 chronic pain and I'm not familiar with the physician or the

1 patient, first, I obtain information, establish a valid  
2 pharmacist-patient relationship, look them up on the PMP, the  
3 Prescription Monitoring Program, see where they've been  
4 getting their prescriptions, what they've been getting. And  
5 then if I'm not familiar with the physician and it's a pain  
6 medication and they're not within the area, I call usually. I  
7 also look up the physician on the MPI site and the DEA site to  
8 see that he's got a valid license and where his address is and  
9 what have you.

10 Q. Now, what's the standard for a pharmacist to be able to  
11 fill a prescription? What is it you have to determine?

12 A. Well, I think they're -- the board would say at meetings  
13 there is several things that would throw up red flags. If you  
14 look at any of those things and see things that look like red  
15 flags -- if I had a patient come here from, say, Richmond,  
16 Virginia, just that's a long ways away for their address to be  
17 there to be here. But you have to keep an open mind as a  
18 pharmacist because I've been surprised over the years at how  
19 many reasonable explanations there are for things that fall  
20 directly under the red flag.

21 So some patients are -- I'm lacking for the  
22 terminology -- they have two addresses. You know, they live  
23 in wintertime in Richmond and then in the summertime come back  
24 to Tazewell and stay for a couple months. My parents live in  
25 Brownsville and come to Tazewell for a few months.

1 Explanation of why the distance is or what's going on and fill  
2 that out.

3           You know, if the dosage was reasonable or if it's  
4 higher than usual seeing on morphine equivalents where it  
5 might be questionable and it's a new patient, like I said, I  
6 can look at the PMP, see what they're on, see if they  
7 developed tolerance, see if the dose is reasonable. If I had  
8 a question, then like I said, I would call Smithers. When I  
9 had questions if he had patients changing from one thing to  
10 another or whatever, if the insurance would flag some things  
11 because they like to establish a prolonged, extended-release  
12 maintenance medication and then have breakthrough pain  
13 medication, sometimes they would say things are duplicate  
14 therapy and what have you. So we get diagnosis and previous  
15 history and information. When I'd call, if the answers don't  
16 give me the warm fuzzies, I --

17           MR. LEE: Your Honor, I'm going to object at this  
18 point to any conversations the witness had with the defendant.  
19 Those would be hearsay statements and inadmissible.

20           THE COURT: I believe you were just discussing  
21 generally why you called --

22           THE WITNESS: In general.

23           THE COURT: -- physicians.

24           But I think you answered the question, so wait for  
25 the next question.

1 BY MR. WILLIAMS:

2 Q. Now, isn't it true that a pharmacist has to find that  
3 there's a legitimate medical purpose behind -- before you can  
4 fill the prescription?

5 A. Well, that makes sense, yes, sir.

6 Q. Okay.

7 A. You know, if there's any question that there wasn't,  
8 then, you know...

9 Q. And did you fill all Dr. Smithers's prescriptions?

10 A. Well, I'm not going to assure you that I filled all of  
11 them because some patients may come, look at it, and may be a  
12 little bit too early or they may have been from a little bit  
13 too far of a distance. If a patient's residence was above  
14 Princeton toward Beckley, I would tell them I think they  
15 passed up too many pharmacies on the route to get to me for me  
16 to find that reasonable. So I kind of don't just fill any  
17 prescriptions just because they're a particular doctor.

18 Q. Okay. All right.

19 MR. WILLIAMS: If I may have just a moment,  
20 Your Honor.

21 THE COURT: You may.

22 MR. WILLIAMS: I think that's all, Your Honor.

23 THE COURT: All right. Cross-examination?

24 ///

25 ///

**CROSS-EXAMINATION**

BY MR. LEE:

Q. Morning.

A. Good morning.

Q. Mr. Hayes, you said you owned Hayes Pharmacy; is that correct?

A. Yes, sir. Well, the bank owns it, but I'm making the payments.

Q. I understand. Are you the only pharmacist that works there?

A. I occasionally have someone fill in for me, like today. I've been trying to work six days a week. But every now and then I take about a half a day off now. When I had custody of my children, I used to take two days off a week.

Q. Okay. And who are the other pharmacists that fill in for you?

A. I've had several. Right now, Pete Vladimir, he's filling in for me. He used to be the pharmacist at Kmart. And I have another pharmacist that's just recently started helping, Jessica. But over the years I've had multiple pharmacists in the area. You can usually talk to them. If they're not a direct competitor close by, they're willing to pick up a day here and there, say, if you're going on vacation.

Q. Back in 2015 timeframe -- I'm sorry, 2017, who are the other pharmacists that might have been helping you out?

1 A. That's close to the time Gazelle Bowman used to fill in  
2 for me a lot. I don't know if she still was at that point.  
3 And I had a couple other different ones, one of my friends Ray  
4 Lassiter that appeared and filled in for me a few times. And  
5 Megan Smith was a student that did rotations at my pharmacy.  
6 And, after Gazelle, she worked for me for a couple years  
7 covering two days a week while I had child custody.

8 Q. Okay. And this is something that shows my ignorance as  
9 to how pharmacists can dispense drugs, or Schedule IIs anyway.  
10 Can anybody fill a prescription or does it have to be the  
11 person whose name is on the prescription?

12 A. Oh, someone else can come on behalf of the patient. The  
13 laws have to allow for, say, if you were in an accident and  
14 you were bedridden, you can't make it to the pharmacy. So  
15 there are rules and steps and ways to do that.

16 Generally, we can work past if you just come from  
17 the ER or the hospital, released from the ICU or a dental  
18 procedure or something, critical care or urgent care from an  
19 accident or something. But we still get an ID of the person  
20 obtaining the prescription and their relationship to the  
21 patient and as much information as possible. And I always  
22 request that at their earliest convenience, when the patient  
23 is able, even if they could come through the drive-through, to  
24 have an ID so I can meet the patient to solidify our  
25 pharmacist-patient relationship. We do, but we don't leave

1 those patients not treated just because they're bedridden.

2 Q. Okay. All right. You're familiar with the what's been  
3 called the "opioid epidemic"?

4 A. Very.

5 Q. And would you agree that's been having very destructive  
6 consequences on Southwest Virginia?

7 A. Unbelievably. It was very enlightening, the Board of  
8 Pharmacy, last year and the year before that, their continuing  
9 education directed right on that and big changes.

10 Q. And, but fair to say, you're a pharmacist in this part of  
11 the country. You've known about the opioid problems that  
12 people have been having, communities have been having for more  
13 than just a couple years but for decades or longer; right?

14 A. Oh, yes, sir.

15 Q. Okay. So it's no surprise to you that opioids are being  
16 abused and distributed and causing great harm on our  
17 communities.

18 A. Correct.

19 Q. Okay. And, for that reason, you would agree that there  
20 needs to be extra care when physicians are prescribing those  
21 medications?

22 A. When they're prescribing or dispensing and what have you.  
23 You know, it would be nice if you could see into a person's  
24 soul and they're actually truthful, honest, and their pain  
25 level. But you can't do that, so do the best you can, give

1 the benefit of the doubt. And, if anything comes up  
2 questionable, I ask the patient to call the doctor, do  
3 everything that we can. And I -- if a patient becomes  
4 forceful or threatening in any way to obtain a narcotic, I  
5 send them to jail. I don't play with that.

6 Q. And you would agree with me that these controlled  
7 substances that Dr. Smithers was prescribing, they were  
8 powerful Schedule II narcotics, weren't they?

9 A. Yes, sir.

10 Q. Oxycodone, powerful drug?

11 A. Yes, sir.

12 Q. Oxymorphone, powerful drug?

13 A. Yes, sir.

14 Q. Are you familiar with what Opana ER is?

15 A. Opana is oxymorphone, yes, sir.

16 Q. Is that still available?

17 A. Yes, sir.

18 Q. Hydromorphone, it's a powerful drug?

19 A. Yes, sir. Dilaudid.

20 Q. Morphine sulfate, MS Contin, powerful drugs?

21 A. Yes, sir.

22 Q. You said you thought you had 6 to 12 patients of  
23 Dr. Smithers. Would the number 25 be more accurate?

24 A. It wouldn't surprise me. I've got a lot of patients. I  
25 do know and I do recall calling Dr. Smithers several times and



1 it stuck in my mind because he was courteous and professional  
2 and said, "If you have any questions ever, here's my cell  
3 phone. I have a lot of patients that have a great deal of  
4 pain," and explained that and told me the diagnosis, so...

5 Q. I wasn't asking what the conversation was.

6 A. Got it.

7 Q. My question was: You said you had 12 patients of his,  
8 would 25 patients be more accurate?

9 A. Like I said, it was a guesstimation. There was probably  
10 a larger amount before he moved further away to Roanoke and  
11 Salem. Then a lot -- a majority followed him, but not all.  
12 So the numbers did fluctuate from one time to another.

13 Q. Okay. Now, you keep mentioning that Dr. Smithers was in  
14 Roanoke or Salem. Is that what he told you?

15 A. I think I had an address in that area. I could go back  
16 and look at my records. It's just I'm going off the top of my  
17 head. I did not take time to research any of this on  
18 Smithers. Come straight in here without looking at any  
19 information. Didn't have time. Got notified yesterday  
20 evening. Changed my schedule. Came straight here. So this  
21 has been several years ago. I'm telling you the best I can to  
22 the best of my ability without looking at my records as to the  
23 exact address. But I know it was out that distance. I  
24 thought it was more than a couple hours' drive. But typically  
25 I see a lot of patients treated from Roanoke and Bristol for

1 chronic pain because they don't generally do that with a  
2 primary care physician.

3 Q. All right. Martinsville, Virginia, is where  
4 Dr. Smithers's practice was located.

5 A. Is that not close to Salem and Roanoke?

6 Q. It's not, no. It's --

7 Would it be fair to say it's at least a  
8 two-and-a-half-hour drive from Tazewell?

9 A. To Martinsville?

10 Q. Yeah.

11 A. I'm not sure.

12 Q. Have you ever been to Martinsville?

13 A. No. But if I saw Martinsville, I would have looked it up  
14 in the distance before I called to try to find out why a  
15 patient was going that distance. It's just what I do every  
16 day.

17 Q. So it never red flagged to you that these 25 patients of  
18 yours -- or Dr. Smithers, were filling at your pharmacy from  
19 the Tazewell, Virginia, area were traveling over two and a  
20 half hours to --

21 A. Oh, it definitely did. That's why I called him to talk  
22 to him about we've got patients traveling this far a distance  
23 and coming to our pharmacies, still. What's going on?

24 And he said, "Tom, I was treating these patients. I  
25 established a relationship with them. They have confidence in

1 me, and I told them they could, but I was surprised at how  
2 many people did and would take the time to drive the distance  
3 to maintain a relationship with the physician.

4 Q. Your brother was a patient of his, wasn't he?

5 A. Yes, sir.

6 Q. And he was receiving oxycodone, oxymorphone, oxycodone,  
7 oxymorphone.

8 A. Oh, yes, sir.

9 Q. Okay. And he had a drug problem, didn't he?

10 A. Yes. He had chronic pain and a drug problem. He's with  
11 hospice now, doesn't weigh 90 pounds. He's had pancreatic  
12 cancer. He's had horrific disease states where he's suffered  
13 his whole life. But like a lot of patients, once they get  
14 started and have a legitimate need for pain medication, they  
15 still develop an addiction and do not use good judgment and  
16 overuse. Tim now has to have hospice watch him and fill up  
17 all his medication on a timed-locked box, and he can barely  
18 get up and walk.

19 Q. He was actually convicted of drug distribution, wasn't  
20 he?

21 A. I have never took time and effort to find out what my  
22 brother's charges were or what he had legal problems with. I  
23 have not had association with my brother with business since  
24 1995. We had a farm together. And we're still brothers, but  
25 I don't get involved in his business with what his legal

1 matters were.

2 Q. Well, you were filling his prescriptions, weren't you?

3 A. No. I did stop filling his prescriptions when --  
4 whenever he got indicted. But then when they released him to  
5 Charlottesville, Virginia, and he had pancreatic cancer and  
6 contacted his physicians and talked to them and hospice,  
7 Kristen Thompson-Whit, a nurse practitioner, I've been trying to  
8 help them supply his medications in the locked boxes again.  
9 But for a brief period, I didn't fill his prescriptions at  
10 all.

11 Q. Okay. But you were filling his prescriptions when he was  
12 going to Dr. Smithers in 2015.

13 A. I did.

14 Q. And it was right after that that he got indicted, wasn't  
15 it?

16 A. That Tim got indicted?

17 Q. Correct.

18 A. I think it was around 2015.

19 Q. Mm-hmm. And you never questioned that your brother was  
20 traveling two and a half plus hours to see a doctor?

21 A. Oh, I did. I called on him specifically.

22 Q. And got -- and you knew at that time that he was a drug  
23 user or drug addict; right?

24 A. I knew Tim was a drug addict? No, sir. I knew that he  
25 had chronic pain. I mean, Tim never went more than three or

1 four months without getting dehydrated to the point that he'd  
2 be in the hospital on IVs for a prolonged amount of time. The  
3 family had always told me that with his pancreatitis, that if he  
4 was to continue to drink alcohol -- because he's been an  
5 alcoholic his entire life and ended up dehydrated in the  
6 hospital. So I didn't realize that he had a drug problem.  
7 Most all of his medications looked reasonably justifiable for  
8 his disease state.

9 Q. And Heather Hartshorn --

10 A. They will tell you that, too, at the hospice. As long as  
11 Tim is drunk, he can sit and answer a question to you. He's  
12 an attorney and he's very knowledgeable. You could come back  
13 an hour later and ask the same question, he would not recall  
14 the answer and give you a different answer. He's drank for so  
15 long, he does not have a clear mind.

16 Q. You were filling Heather Hartshorn's prescriptions also?

17 A. Heather who?

18 Q. Heather Hartshorn.

19 A. I remember the name.

20 Q. Do you remember what happened to her?

21 A. Did -- did she overdose?

22 Q. Is that what you recall?

23 A. Vaguely. I think that is what happened.

24 Q. She overdosed on prescriptions filled at your pharmacy?

25 A. Yes, sir.

1 Q. You're aware of that?

2 A. Yes, sir.

3 Q. Two days after you filled them --

4 A. Yes, sir.

5 Q. -- or two days after --

6 A. I think I do remember the incident.

7 Q. -- or the day after?

8 A. Yes, sir.

9 Q. Now, you don't actually know what happened between  
10 Dr. Smithers and his patients.

11 A. No, sir.

12 Q. You don't know what sort of exams, if any, were given,  
13 what sort of diagnosis, if any, was made, what sort of --

14 A. On the majority of the patients, I would not. Like I  
15 said, with my brother, red flag, and I would call him and  
16 asked about traveling the distance and the medications. A  
17 very logical, medical explanation was given. I mean, I felt  
18 comfortable with when I talked to him at the end of the  
19 conversation. But I wouldn't have called him if I wasn't  
20 uncomfortable with him to begin with.

21 And I think you'll find on any of Tim's  
22 prescriptions and Heather's prescriptions that there will be  
23 extensive notes about me questioning them and the reasonable  
24 medicinal justification for the use of the dosages and the  
25 medication.

1 Q. All right. Again, you don't know what happened between  
2 the doctor and the patients, do you?

3 A. I was never there. No, sir.

4 Q. You don't know what medical conditions any of these  
5 patients had?

6 A. I do not diagnose.

7 Q. Okay. And you've talked about red flags that you  
8 yourself would find to be troubling; correct?

9 A. I would find them to be a red flag. But, like I said, on  
10 a daily basis we have patients that have chronic pain that  
11 travel to Bristol. I'm from Tazewell. The day my wife had a  
12 car accident, she's going to Dr. Brasfield neurological in  
13 Bristol. To travel two hours in Tazewell is not unreasonable.  
14 There's not anybody in Tazewell that's doing a reasonable job  
15 of being a neurosurgeon that I know of.

16 Q. First of all, you have to admit that somebody who has  
17 been trained in neurosurgery is very different than  
18 Dr. Smithers's qualifications; correct?

19 A. Correct.

20 Q. I mean, do you know even what sort of training or  
21 specialized training he's had?

22 A. I'm not familiar with what specialized training he would  
23 have.

24 Q. Okay. So your comparison really is very different.

25 A. It's different. But -- and he gave me an explanation of

1     why he treats and that he did treat pain patients.

2     Q.     Right.  So you're basing everything, all the decisions  
3     you're making, solely based on what Mr. Smithers was telling  
4     you; right?

5     A.     What he said and when I researched the DEA site, I find  
6     his DEA, the MPI, and I look up the PMP for patients and  
7     history.  That's all I have to go by.

8     Q.     Well, Mr. Hayes, did Dr. Smithers ever tell you that he  
9     left pre-signed prescription pads in his office and let his  
10    urine collector/staff member fill out which prescriptions  
11    should be given to patients?

12    A.     No, he would never tell me nothing like that.

13    Q.     Would that be a red flag?

14    A.     I would think that would be not the normal practice, and  
15    it would be a hard thing to judge.

16    Q.     Would you fill that prescription?

17    A.     I mean, because I --

18           MR. WILLIAMS:  I'm going to object to what his  
19    qualifications would be to know this kind of information.

20           THE COURT:  I'll overrule the objection.

21    BY MR. LEE:

22    Q.     Let me ask it this way:  Would you fill that prescription  
23    knowing that's what happened?

24    A.     I would probably call and get an explanation.  To tell  
25    you for sure I thought this was very unusual when I first got



1 to Tazewell and started practicing. There was a dentist,  
2 Dr. Stanton. Every prescription he had come in, all day long,  
3 the patients he specialized in had extractions, would have  
4 gauze and blood all in their mouth, and they'd have a stamped  
5 signature and then it would have a different handwriting for  
6 the prescription, and then they'd have a different writing for  
7 the patient's name. And that's a big red flag. And I called  
8 him.

9 And, I mean, I'm right there in town. I've known  
10 him all my life. He was at every football game when I was in  
11 little league. And he said, "Tom, when I get there in the  
12 morning, I sign the prescriptions. Nobody can read my  
13 writing, so I have the nurse write the prescription out. And  
14 then I have the patient print their name on it. So we have  
15 three different handwritings on there."

16 And I said, "As long as you do, I'm going to call on  
17 every one of them and verify them." And I did on every time  
18 we saw one.

19 So that happened sometimes and sometimes there is an  
20 explanation. But, yes, it's a red flag and a call. If there  
21 wasn't a justifiable reason and I didn't have the warm  
22 fuzzies, I would say, "I'm sorry. I can't fill this." If I  
23 couldn't reach Dr. Smithers on the phone to find out if the  
24 prescription had any questions, then I would tell them I'd  
25 have to wait until I can answer the questions that have a red

1 flag. That's what we do.

2 Red flag doesn't mean we just say, oh -- some  
3 pharmacists do that. I ain't talked to -- we don't got it.  
4 That's what they'll tell them. We don't got the medicine.  
5 Well, I don't like to bear false witness, so I don't do that  
6 either.

7 Q. Okay. So you'd fill a prescription filled out by an  
8 untrained staff member at Dr. Smithers's office without  
9 question --

10 A. The law is the doctor has the ability to deem anybody --  
11 he could pick anyone in this room, able to call in a  
12 prescription for him. Just all he has to do is tell you, and  
13 you could call in a prescription for him.

14 Q. For Schedule II controlled substances?

15 A. Schedule II controlled substances have to be written out.  
16 It doesn't say that the doctor has to write it. He just has  
17 to sign it. Like a checkbook, my wife can fill out my  
18 checkbook. She's not on there for signing. I have to sign  
19 it. So that's the way the legal document is.

20 Q. What if you knew that Dr. Smithers's practice in  
21 Martinsville had patients traveling from Columbus, Ohio, to  
22 get controlled substances?

23 A. That doesn't make a lot of sense. When you're getting to  
24 that kind of distance, we're getting into something that's  
25 more like when we had patients traveling from Florida all the

1 way up the east coast on the OxyContin express. When that  
2 initially happened 18, 19 years ago, it blew all of our minds  
3 and there were big changes made. And -- but I don't -- you  
4 know, until we got in a position to learn how to handle that,  
5 it was a learning experience. I mean, nothing like that had  
6 ever happened.

7 Q. Mr. --

8 THE COURT: Let's try to just answer the question  
9 and if --

10 THE WITNESS: That -- it's not reasonable to travel  
11 from Ohio to West Virginia, to Virginia, in between your  
12 pharmacists and your doctor, I don't think.

13 BY MR. LEE:

14 Q. Okay. So that's a red flag if someone is traveling from  
15 Columbus, Ohio, to Martinsville?

16 A. It would be a red flag. Definitely.

17 Q. You would question that prescription, wouldn't you?

18 A. You would what, now?

19 Q. You would question that prescription?

20 A. Definitely.

21 Q. What if Dr. Smithers's patients from West Virginia would  
22 drive to Martinsville to get their prescription, then drive  
23 all the way to Jeffersonville, Indiana, to fill their  
24 prescription?

25 A. That sounds --

1 Q. Sounds crazy, doesn't it?

2 A. Very questionable, yes, sir.

3 Q. That's not questionable. That's crazy, isn't it?

4 A. Well, you know, I like to think that you can look at  
5 something and define it that way. But over the years I found  
6 out there would be things like a special surgeon in one place  
7 that they had to have something done. If it's justifiable, it  
8 is. But it doesn't sound reasonable. The only way you'd know  
9 is start digging. When you get a red flag, you dig until you  
10 find a legitimate answer. If you do not, you don't fill it.

11 MR. LEE: No further questions, Your Honor.

12 THE COURT: All right. Anything further?

13 MR. WILLIAMS: Just a couple questions.

14 **RECROSS-EXAMINATION**

15 BY MR. WILLIAMS:

16 Q. Mr. Hayes, did you fill a prescription around that same  
17 time of Ms. Hartshorn's death for benzodiazepines for her? Do  
18 you recall?

19 A. I think I did.

20 Q. Okay.

21 A. It's been a long time. I haven't looked at the records,  
22 but it sounds like I did.

23 Q. And, with respect to your regular customers, customers in  
24 that area, did you fill all of Dr. Smithers's prescriptions  
25 for them?

1 A. Not -- I don't think all of them. You know, if there was  
2 not -- if there were red flags that were not answered, then I  
3 may not have filled a couple numerous prescriptions. And  
4 people will tell you, too, if the patient gets loud or  
5 forceful and doesn't have patience with me to answer these red  
6 flags, they either go out the door or I call the police for  
7 them trying to pursue -- obtain a narcotic through threatening  
8 a pharmacist.

9 MR. WILLIAMS: No further questions.

10 THE COURT: Anything further?

11 MR. LEE: No, Your Honor.

12 THE COURT: All right. Thank you, sir.

13 You may step down. Sir, you may leave. Thank you,  
14 sir.

15 All right. We're going to -- ladies and gentlemen,  
16 we're going to take a short recess at this time. If you'll  
17 follow the bailiff out.

18 (Proceedings held in the absence of the jury.)

19 THE COURT: All right. Counsel, we're going to take  
20 a short recess and when we come back, we'll see if the  
21 defendant has any further evidence.

22 We'll be in recess.

23 (Proceedings suspended at 10:06 a.m. and resumed at 10:20  
24 a.m.)

25 THE COURT: All right. Mr. Williams, do you have

1 any further witnesses?

2 MR. WILLIAMS: Yes. I think -- against counsel's  
3 advice, but I think Dr. Smithers has indicated he wishes to  
4 testify at this point.

5 THE COURT: All right. Dr. Smithers, is that  
6 correct?

7 THE DEFENDANT: Yes, Your Honor.

8 THE COURT: All right. Again, you understand the  
9 advice that I gave you?

10 THE DEFENDANT: Yes, Your Honor.

11 THE COURT: All right. We'll have the jury in.

12 (Proceedings held in the presence of the jury.)

13 THE COURT: All right. Ladies and gentlemen, we're  
14 ready to go again. You may call your next witness.

15 MR. WILLIAMS: The defense calls Dr. Joel Smithers.

16 THE CLERK: Please raise your right hand.

17 Do you solemnly swear that the testimony you're  
18 about to give in this case shall be the truth, the whole  
19 truth, and nothing but the truth, so help you God?

20 THE DEFENDANT: Yes, ma'am.

21 **JOEL ADAM SMITHERS,**

22 Called as a witness herein by the Defense, having been first  
23 duly sworn, was examined and testified as follows:

24 ///

25 ///

**DIRECT EXAMINATION**

BY MR. WILLIAMS:

Q. State your name for the members of the jury.

A. Joel Adam Smithers.

Q. Okay. And, Joel, where do you live?

A. I live in Greensboro, North Carolina.

Q. And who do you live with down there?

A. My wife, Angel, and four kids; E., 14; S., 11; A., 4; and B., 2; and a third daughter due in July.

Q. Okay. Now let's talk a little bit about your educational upbringing. Okay. Where did you graduate high school from?

A. I was homeschooled. But Trinity Christian High School -- or Texas Christian High School in Texas.

Q. What did you do in high school? Anything particular?

A. I was president of 4-H and we did forestry competition and worked for my dad. He's a veterinarian.

Q. Okay. And did you go off to college beyond that?

A. No. At the age of 17, I joined a non-profit Christian organization that did disaster relief, The Air, Land, and Emergency Resource Team, and we responded to disasters. I was there from the age of 17 to 21. And we did disaster relief and recovery for tornados, hurricanes, floods. And we did underwater search and recovery and different activities such as that.

Q. Okay. Now, with respect to this, what -- did you

1 eventually go off to college?

2 A. I did. At the age of 21, after I'd been on the staff  
3 there, I went to -- I began my business education, business  
4 college in an accelerated program to complete that in two and  
5 a half years. And then while I was finishing that program, I  
6 also started taking the prerequisite science courses to be  
7 able to go to medical school.

8 Q. Okay. And when did you change your mind to go away from  
9 business into medical school?

10 A. Well, I -- I mean, my whole life I had, from a young age,  
11 really going to back to when I was 12 and went on a mission  
12 trip to Mexico, reroof and pour a roof for a person in Jikad  
13 (phonetic), I discovered how much I enjoyed helping other  
14 people.

15 While I was doing my business education, I  
16 volunteered at a local cancer center and that really  
17 solidified the idea in my mind that I wanted to help people  
18 through medicine.

19 Q. Okay. And I don't know. Did you ever say which college  
20 you graduated from?

21 A. My undergraduate in business is from the Thomas Edison  
22 State University out of Trenton, New Jersey.

23 Q. Okay. Now, you grew up in Texas; right?

24 A. Yes, sir. I grew up on a cattle farm in northeast Texas,  
25 about 30 minutes south of Texarkana.



1 Q. How did you get to college in New Jersey? Was this an  
2 online type college or --

3 A. Yes. It was correspondence, an accelerated program where  
4 I could test out of a lot of subjects. It was originally  
5 created for military people to be able to do correspondence  
6 undergraduate degrees. Then they opened it up to anybody who  
7 wanted to try and move through their coursework faster.

8 Q. Okay. You graduated that when?

9 A. I started that in September of 2001 and graduated in June  
10 of 2004.

11 Q. 2004?

12 A. Yes, sir.

13 Q. Okay. And beyond going from there, once you graduated  
14 from college, you mentioned something about military. Were  
15 you involved with the military in college or anything?

16 A. Not in that -- no, sir. Not at that time.

17 Q. Okay. What did you do after you graduated?

18 A. After I graduated, I worked for a period of time as a  
19 nursing assistant in a county hospital in Arkansas. I lived  
20 with my 88-year-old grandfather at the time, helped take care  
21 of him, and then decided to take additional coursework to be  
22 able to apply to medical school.

23 Q. Okay. And so was the next step in your life to go to  
24 medical school at that point, or --

25 A. It was. I went and did additional training in Emergency

1 Medicine Techniques school, EMT, in Fort Worth, Texas. Then I  
2 worked in Trueport, and at that time had been accepted into  
3 medical school and was -- and that was in 2007.

4 Q. Okay. And where did you go to medical school at?

5 A. Lincoln Memorial University, DeBusk College of Medicine  
6 in Harrogate, Tennessee.

7 Q. And that would have been starting in when?

8 A. I believe July of 2007.

9 Q. Okay. And describe what is a -- what is a doctor of  
10 osteopathic medicine?

11 A. The simplest way I could say it, I guess, it's a  
12 different approach to practicing medicine than allopathic  
13 medicine, which is what you traditionally think of as a  
14 medical doctor, an M.D. The last initials after my name are  
15 D.O. And one of the chief ways that we differ is that in our  
16 education we are taught how -- we spend a little bit more time  
17 doing manipulative training. Some people -- if you saw me do  
18 that on a patient you would say it looks like chiropractic but  
19 it's not. It's very similar. But we're educated in that  
20 arena and have a lot more hands-on training in that regard.

21 Q. Okay. Now, D.O., obviously, is able to prescribe  
22 narcotics; correct?

23 A. Yes, sir. I believe -- yes, sir, that's correct.

24 Q. Now, with respect to this, was there some point in time  
25 that you became involved not only in your schooling but also

1 with the Air Force?

2 A. Yes, sir, that's correct. I believe in the first or  
3 second year of medical school I was accepted into the Air  
4 Force's Health Profession Scholarship program and that summer  
5 began officer training school in Montgomery, Alabama.

6 Q. And describe why were you involved in that program? What  
7 was that benefit of that program? Or why did you do it?

8 A. Well, most my life I had wanted to be in the military. I  
9 didn't know what capacity I would serve, but I'd wanted to.  
10 Both my grandfathers fought in World War II and I had an uncle  
11 that died in Vietnam. I wanted to serve, so that was an  
12 opportunity to do that. They accepted me into the program.

13 It was an application process, and they accepted me.

14 Q. Okay. Did they help pay for school or anything through  
15 that program?

16 A. They did, yes, sir.

17 Q. Okay. Did you have a commitment for anything afterwards?

18 A. I did a four-year commitment.

19 Q. Okay. And that would have been after what?

20 A. Post graduation. Well, the four-year commitment wouldn't  
21 start until after internship period had been completed.

22 Q. Okay. So you would graduate school, go through  
23 internship, then you would have started your four-year  
24 commitment to military; is that correct?

25 A. Yes, sir, that's correct.

1 Q. Now, with respect to -- with respect to this, where did  
2 you do an internship at?

3 A. So I graduated medical school in 2012 and was accepted  
4 into an internship training program in Morganton,  
5 North Carolina, at Blue Ridge Health Care.

6 Q. Okay. And did you counter -- what were you training in,  
7 specifically? What was your role in that?

8 A. Yes, sir. That was rotating transitional internship,  
9 which that just means that you rotate through a variety of  
10 different services. You rotate through -- I think my first  
11 service I was on was obstetrics and gynecology, delivering  
12 babies, then internal medicine in the hospital, pediatrics,  
13 and you got some electives, and one of my electives was pain  
14 management.

15 Q. Okay. So that kind of got you -- you had some training  
16 in that. When you say "training," what kind of training?

17 A. Well, so when you rotate through each of those  
18 specialties, you would be with -- in my training program, you  
19 would be with another physician. They would be your attending  
20 physician. They would give you jobs, tasks. You'd probably  
21 spend the first few days more or less watching what they do.  
22 And then they would basically expect you to be able to  
23 replicate on most of the general patients and continue to  
24 teach you and give you more jobs and responsibilities as you  
25 showed the aptitude throughout the month of training.

1 Q. Now, you ran into some problems in the training in  
2 North Carolina, didn't you?

3 A. I did. I was six weeks from completing that program in  
4 May, the end of May of 2013, and I made possibly one of the  
5 worst decisions of my life. I had worked at the hospital 14  
6 or 16 hours that day and some senior residents asked me to  
7 come get a bite to eat and have some beer with them. Against  
8 my better judgment, I did that. And driving home, somewhere  
9 between midnight and 1:00 a.m., I sped through a stoplight,  
10 and Officer Lloyd -- there in Morganton, North Carolina,  
11 Officer Lloyd pulled me over, said he smelled alcohol on my  
12 breath. At the time I was six weeks away from starting my Air  
13 Force training to be a doctor in the Air Force. So I -- I did  
14 panic, and I made a bad decision and told Officer Lloyd that I  
15 was headed to the hospital to see a patient when I was not.

16 Q. Okay. And as a result of that, what happened with the  
17 internship?

18 A. As a result of that, I was called into the office the  
19 next day through a series of events and was given the choice  
20 to continue in the -- I was given the choice in a matter of  
21 three days to either resign from the internship or be fired.

22 Q. Okay. And you chose to resign; correct?

23 A. I chose to resign, yes, sir.

24 Q. Okay. Now, did something else, again, happen to you at  
25 that point?

1 A. The same day that I resigned from my internship, my wife  
2 at the time, her attorney, who I didn't know she had an  
3 attorney, she called me as I was driving down the interstate  
4 and asked me where to send divorce papers to. And that was a  
5 pretty bad day.

6 Q. Okay. Now, after all this happened in North Carolina,  
7 where did you go after that?

8 A. Within about three months, I had found a new residency  
9 program, a new internship program in Bluefield, West Virginia.

10 Q. Okay. And why West Virginia? Anything particular about  
11 West Virginia?

12 A. No, sir. At that point, with that type of problem on my  
13 record, I was grateful to be able to go anywhere to continue  
14 my training at that time.

15 Q. Okay. Who did you go to work with there?

16 A. My director of medical education was Jonathan --  
17 Dr. Jonathan Yates.

18 Q. Okay. And how long were you in that training program?

19 A. I successfully completed my internship there. I did  
20 another nine months of internship and was planning to begin my  
21 internal medicine residency program there. I found out the --  
22 again, the end of May of 2014, that the hospital board had  
23 voted to de-fund the internal medicine residency program. And  
24 so at the end of May that year they informed me that I no  
25 longer was going to be able to have a position in internal

1 medicine.

2 Q. Okay. This was all in Bluefield?

3 A. Correct. This was in Bluefield, West Virginia.

4 Q. This was in what time period?

5 A. May, June, 2014.

6 Q. So roughly around this time, with that program gone,  
7 where did you go? Or what was the next step in your process?

8 A. At that point I tried to find another residency program.  
9 The way the residency -- the way doctors get patched into the  
10 residency program, it typically happens in February, March is  
11 when you're trying to find those positions. So by the time  
12 this happened, there were really no positions for me to go to  
13 in the area.

14 And I was remarried at that point, and my family was  
15 in Greensboro, North Carolina. So I had conflicting issues to  
16 deal with in regards to family responsibility. And so I --  
17 not being able to find a residency to start in, I applied for  
18 full medical licensure from the Medical Board of Osteopathic  
19 Medicine.

20 Q. Were you granted that licensure?

21 A. I was, I believe by September of 2014. It took a few  
22 months.

23 Q. Did you have to go through any training or anything like  
24 that to get that?

25 A. I believe they required some CME -- in West Virginia they

1 have your general medical license, and then they also require  
2 you to get a license for prescribing controlled substances.  
3 So I think there was some training I had to do to be able to  
4 get both of those licenses.

5 Q. Okay. And so once you were granted that license, where  
6 did you go?

7 A. I drove around the state. I'd applied to several  
8 different federally-qualified health centers, which are rural  
9 health centers in every -- I think every state has one. But  
10 they're grant-funded rural health centers to provide health  
11 care to the rural population. West Virginia has quite a few.  
12 And not having completed a residency program, I wasn't board  
13 certified, so it's -- it makes it much more difficult when  
14 you're not board certified to be able to find a job as a  
15 physician.

16 So I had contacted someone in Charleston, I think,  
17 who helped -- that worked the federally-qualified health  
18 centers in West Virginia, and they got me interviews. And I  
19 drove around the state and was given a job offer at a couple  
20 of -- I think three different locations. And I chose the one  
21 closest to Greensboro. It's outside of Princeton, West  
22 Virginia.

23 Q. That would be the one in Bluestone; is that correct?

24 A. That's Bluestone Health Care.

25 Q. Bluestone Health Care?



1 A. Yes, sir.

2 Q. Now, how long did you work for Bluestone Health Care?

3 A. I began working there in October of 2014, I believe. And  
4 worked there until April or May of 2015.

5 Q. Okay. And so April or May of 2015 you're still in  
6 Bluestone. Why leave Bluestone?

7 A. There were a few reasons. One of them was I was not  
8 seeing enough patients per day. The administrator there  
9 wanted me to see more people per day, and I didn't think I  
10 could provide adequate care if I saw more people per day. So  
11 that was kind of a major issue for me --

12 Q. Okay.

13 A. -- to try and find other places to go.

14 Q. So in 2014 you decide to leave Bluestone; is that  
15 correct?

16 A. Yes, sir, in the spring of 2014.

17 Q. And what did you do at that point?

18 A. So at that point I had looked at a few different options.  
19 One of the things I was very interested in, and I had done at  
20 Bluestone, they had kind of a combination service. We did  
21 urgent care. We also did primary care medicine, and we had  
22 our own pharmacy inside of the facility as well. And so I was  
23 interested in probably starting my own urgent care at that  
24 point in time and had been looking at different ways to do  
25 that.

1 Q. Okay. And what did you do at that point? What's the  
2 next step?

3 A. So I was put in touch with a physician by the name of  
4 Dr. Bloom through another physician who had previously worked  
5 at Bluestone, I believe Dr. Clarkson, who I'd never met but I  
6 talked to him on the phone. And through Dr. Bloom, I guess,  
7 he was the medical director for the top pain clinic in  
8 Bethany, West Virginia, or Weaver, West Virginia, which is  
9 right next to Beckley, and they expressed an interest in an  
10 urgent care, primary care facility being inside their  
11 facility. They saw a lot of patients a day, between 100 and  
12 150 patients a day, and a lot of them needed primary care  
13 and/or urgent care type services.

14 Q. Okay. Now, did you set up an urgent care?

15 A. So that was, I believe, in May, end of June of 2014. I  
16 did start -- I moved into an office space there. They have a  
17 really large office building. And so I had -- I was given an  
18 office space to set up an office in there. And after about  
19 two weeks it became clear that they were not going to get  
20 renewed for their pain clinic licensure, which is something  
21 that West Virginia had just started at that time. And their  
22 license, I believe like most of the clinics in the state at  
23 that time, was revoked and they were not allowed to continue  
24 to see patients.

25 Q. And was this in a -- was this a separate building? Was

1 it a medical arts building? Was it a hospital?

2 A. It was a large -- it almost looked like a house, but it  
3 was a large office building, well over 12,000 square feet. It  
4 was big. I believe it used to be the accounting department  
5 for Jim Justice, the governor of West Virginia. So it's a  
6 large building.

7 Q. So you've opened the urgent care. All the sudden now you  
8 found out that the center is about to close?

9 A. Correct.

10 Q. Okay. What happened at that point?

11 A. At that point I immediately -- I had laid the groundwork  
12 and I believe had gotten a business license or was about to  
13 get a business license for my urgent care, Priority Urgent  
14 Care, so I began looking for a medical office space to open  
15 that service in.

16 Q. Okay. How did the business go? In other words, what --  
17 patients -- did you --

18 A. So I found an office space in the Beckley Medical Arts  
19 Building just down the hall from LabCorp and a radiology  
20 office where they did X-rays and ultrasound. I was next door  
21 to a dentist, and there's a pulmonologist across the hall,  
22 sort of catty corner. It was 4,000 square feet of office  
23 space, wasn't very big. But that's where I opened the urgent  
24 care.

25 Q. Did you have a lot of patients?

1 A. First day I had no patients. That was a Monday. This  
2 would have been in June, I believe. And then Tuesday I -- it  
3 was like someone opened a water spigot. I mean, it was more  
4 people -- and I was -- I hadn't hired any staff yet. I was  
5 just -- it was just me that first day -- or that second day.

6 Q. Okay. What were these patients coming in complaining  
7 with?

8 A. They were complaining that they had lost access to their  
9 chronic pain physician and that they were in severe pain.  
10 They had run out of medication. Some of them were so sick  
11 that I sent them to the emergency room. It was -- I had never  
12 experienced anything like that in the United States of  
13 America.

14 Q. Okay. Now, as far as these patients, how long did you  
15 continue to operate the urgent care?

16 A. So I think I operated the urgent care in West Virginia  
17 for another maybe two months. I don't have a calendar in  
18 front of me, but it was the rest of June, maybe, then July and  
19 August.

20 Q. Okay. Now, was there a reason that you left West  
21 Virginia?

22 A. There were a few reasons, one of which was the tons of  
23 patients that were continuing to come into my office that I  
24 was refusing to see; and the other was that the laws in West  
25 Virginia were such that if anyone treated more than 50 percent

1 of their patients for chronic pain with anything more than  
2 Tramadol, they were labeled a pain clinic and were subject to  
3 being shut down or fined. So I didn't see any way to be able  
4 to take care of these people adequately and stay in a state  
5 that was -- you know, had that type of law in place.

6 Q. Now, where was your family at this time?

7 A. My family was in Greensboro the entire time.

8 Q. Okay.

9 A. I would go home on the weekends.

10 Q. All right. And so were you looking for something closer  
11 to home?

12 A. Yes, sir, I was.

13 Q. Okay. And did that opportunity present itself?

14 A. It did. My wife Angel, she found a medical office that  
15 had recently become available in Martinsville, Virginia. And  
16 it was about a half mile down from the hospital, right across  
17 the street from the minor league baseball stadium, had two  
18 doctor offices below it. It seemed like a good place to open  
19 a medical practice.

20 Q. Okay. Now, with this -- you had to get licensed in  
21 Virginia; correct?

22 A. Yes, sir.

23 Q. Okay. And did you get the license?

24 A. I did, yes, sir.

25 Q. Okay. And when did you move to Martinsville?

1 A. I believe the license was granted in August of 2015, and  
2 I moved shortly thereafter. I believe it was the last week of  
3 August of 2015 is when I moved my office by myself from West  
4 Virginia to Martinsville.

5 Q. Okay. What was your intent when you moved to Virginia,  
6 as far as what type of office and everything you wanted to  
7 have?

8 A. Well, I mean, initially, the patients that continued to  
9 come to my office and see me, you know, I was going to try and  
10 take care of them. I made it clear to them that my goal was  
11 that they would find doctors close to home to treat them.  
12 Because I didn't -- I didn't think it would be a long-term  
13 situation because I thought it was so catastrophic what I had  
14 seen in West Virginia with all -- I mean, thousands of  
15 patients not having treatment -- that I thought that situation  
16 would get corrected quickly and that doctors' offices would be  
17 able to take patients again. I mean, everybody was telling me  
18 they had a six-month wait list or one-year wait list to see a  
19 chronic pain doctor or even a primary care doctor that would  
20 treat chronic pain. So I was hopeful that they would go back  
21 to that, to their home states and be treated there.

22 Q. Okay. Now, once you're in Martinsville, you began to see  
23 patients.

24 A. Yes, sir.

25 Q. Did you have patients that followed you from West

1 Virginia?

2 A. I did, yes, sir.

3 Q. Okay. You began to have other patients; correct?

4 A. Yes, sir.

5 Q. And where were all these patients from?

6 A. Well, a few patients from Virginia, but most of them,  
7 through word of mouth, would come from Kentucky and West  
8 Virginia. Those were the main two places. I think there were  
9 a few patients from Tennessee because Tennessee had shut down  
10 some clinics, as well. And, I mean, it was just kind of word  
11 of mouth. I never really advertised. I had a sign out in  
12 front of my office.

13 Q. Why deal with this type of practice? Did anything change  
14 in your mind as you began this practice?

15 A. I mean, initially, no. I thought I had needed more  
16 training, and I sought that out.

17 Q. What kind of training did you get?

18 A. I went to the American Society of Interventional Pain  
19 Physicians controlled substance course in Chicago to go  
20 through their certification program.

21 Q. Was that in July of 2015?

22 A. Yes, sir, that was.

23 MR. WILLIAMS: May I approach the witness,  
24 Your Honor?

25 THE COURT: You may.

1 BY MR. WILLIAMS:

2 Q. Dr. Smithers, I'm going to ask you, what is that a copy  
3 of?

4 A. This is a copy of my completion certificate with the  
5 American Board of Interventional Pain Physicians.

6 Q. And you state you attended that course in July of 2015?

7 A. Yes, sir.

8 Q. And how many hours was that, do you know?

9 A. I want to say it was at least around 15, maybe more.  
10 Maybe 20 or 25 hours, I'm not -- it doesn't say here on the  
11 certificate. But it was intensive.

12 Q. You were awarded that certificate; is that correct?

13 A. Yes, sir.

14 MR. WILLIAMS: Your Honor, at this time we'd ask to  
15 move that as Defense Exhibit 2 -- or 3 I think it is now.

16 THE COURT: It will be admitted.

17 (Defense Exhibit 3 received.)

18 BY MR. WILLIAMS:

19 Q. Now, Dr. Smithers, have you received any other training  
20 in pain management or controlled substance prescribing?

21 A. Prior to that I had completed CME in West Virginia, the  
22 required -- I believe it's three or three and a half hours of  
23 medical education in regards to controlled substances and, you  
24 know, basically the pharmacology of controlled substances,  
25 some of the science that we have to know, and then that was



1 the other activity I completed.

2 Q. Okay. Now, once you sort of completed this course,  
3 where -- what did you begin to do as far as seeing these  
4 patients? Did you have a change in philosophy or anything  
5 that --

6 MR. RAMSEYER: Your Honor, the course that he's  
7 talking to, he went to -- according to.

8 MR. WILLIAMS: That's a different one. I was just  
9 giving you a heads up on that.

10 MR. RAMSEYER: That's all right. Go ahead.

11 BY MR. WILLIAMS:

12 Q. Let me back up, see where I was.

13 Did you have any kind of change of philosophy after  
14 you began to treat these patients?

15 A. I did. These patients were on medicine that, you know --  
16 I guess what I had seen with these patients, I think what in  
17 my mind made them different -- or similar to other patients  
18 I'd seen, honestly in my practice at Bluestone, was that, you  
19 know, other physicians followed a model where they prescribed  
20 patients really high doses of immediate release narcotics,  
21 like oxycodone 30 milligrams. And they'd give them 120, 150,  
22 over 200, 300 pills in cases. And the pattern that I saw as I  
23 interviewed these patients and talked to them about their  
24 chronic pain is that they would have these -- they would have  
25 spikes in severe pain, and they would take their medicine. It

1 would last, you know, two to four hours, and then their severe  
2 pain would return.

3 And so I began to take information I learned in  
4 these courses and compare that with my experience reading  
5 these patients and find that extended-release medicine gave  
6 them a better control of their pain and also gave them better  
7 quality of life. And so my goal began to be to try to get  
8 them off the immediate-release narcotics as much as possible.  
9 The other problem with the immediate-release narcotics, as has  
10 been pointed out, is their abuse potential. They're easily  
11 abused.

12 Q. Okay. Now let's fast forward the record just a little  
13 bit. Take me to the date that the search warrant was issued  
14 on your office. Tell me a little bit what happened at that  
15 time.

16 A. Yes, sir, that would be March 7 of 2017.

17 Q. Okay. And what happened on that day?

18 A. I was at the office. I was in seeing, I believe, my  
19 first patient of the day, around 8:00 or 9:00 a.m. And  
20 Mr. Wilson, the compliance manager at my office, came and  
21 informed me that there were two DEA agents that he had seated  
22 in the kitchen that needed -- that had requested to speak with  
23 me.

24 Q. Okay. And did you comply with everything they asked that  
25 day?

1 A. Absolutely, yes, sir.

2 Q. Okay. Now, there was a search that was done of your  
3 vehicle; correct?

4 A. Yes, sir, there was.

5 Q. Okay. And what was found in that -- in your vehicle?

6 A. They found what we've all seen on the pictures. They  
7 found a backpack with 70 pill bottles with medications that  
8 patients had returned, I believe most of which weren't  
9 controlled substances, some of which were controlled  
10 substances, Ms. Fisher's returned medication, and then in the  
11 glove box there was a large amount of cash.

12 Q. Okay. Let's talk a little bit about what the cash was.

13 Okay. Why were you carrying around a large amount of cash?

14 A. That was money that had been saved to go into a credit  
15 union account my wife and I had just opened a couple weeks  
16 prior to begin -- we had signed up with the IRS for the  
17 electronic payment transfer service, I believe it's called.  
18 And that money was going to be deposited into the credit union  
19 account so that the taxes could be paid on a quarterly basis.  
20 And that was going to be the initial deposit into that  
21 account.

22 Q. Now, so you had set up -- you were going to set up a tax  
23 thing to pay it; is that correct?

24 A. Right. We already set up -- I believe the week before  
25 the search warrant was executed, we already set up and had

1 gotten a confirmation letter from the IRS that their  
2 electronic payment system was linked with our newly-opened  
3 credit union account.

4 Q. So you had this money that you were getting ready to put  
5 into that account; is that correct?

6 A. Yes, sir, that's correct.

7 Q. And what about the pills?

8 A. The medications had been in that backpack since I moved  
9 to Martinsville. And the week prior to the search warrant  
10 being executed is when Mr. Wilson's father had passed away in  
11 Tennessee and he had to leave suddenly. And after I walked  
12 Ms. Fisher out because I think it was after -- it was dark  
13 outside. It was after 7:00 or 8:00 when I walked her out to  
14 her car that night. She was the last patient. When I came  
15 back to turn off the light, her medicine was still on the  
16 counter in the baggies that she had brought it in. Because  
17 normally Mr. Wilson took care of the distribution with the  
18 patient in the bathroom and I then I just saw the form in the  
19 chart.

20 So at that time, I put -- I remember that I had that  
21 backpack. And it was in a locked office in the back. My  
22 office was about 4,000 square feet. And there were rooms in  
23 the back that we just -- we didn't use. One of them was a  
24 storage room that was locked. And that's where this backpack  
25 had been. And so I put that medicine with that, and my

1 intention was to take it to the Henry County Sheriff's  
2 Department and have them take control of all those medicines.  
3 I was just going to give all of them to them.

4 Q. Okay. When were you planning on doing that?

5 A. That week.

6 Q. Okay. Now, have you ever sold any pills?

7 A. No, sir.

8 Q. Have you ever taken anything that's not prescribed to  
9 you?

10 A. No, sir.

11 Q. Did you ever take any of those pills?

12 A. No, sir.

13 Q. Did you ever give any of those pills out to another  
14 patient?

15 A. No, sir.

16 Q. Now, what I'd like to do is let's go through -- as you  
17 set up your practice, okay, were there certain safety  
18 precautions you tried to implement throughout the time of your  
19 practice?

20 A. Yes, sir.

21 Q. When I say "safety precautions," I'm talking about --  
22 we're talking about high-level narcotics and stuff. Were  
23 there things that you tried to implement in your practice to  
24 be able to make sure these things weren't being abused and  
25 stuff?

1 A. Yes.

2 Q. Describe some of the things you set up.

3 A. So I would go back to when I had the urgent care in West  
4 Virginia. I -- even before that when I was at Bluestone, and  
5 the reason I had taken back patients' medications, which I  
6 later found out you're not supposed to do, I had a patient  
7 that had really severe gout. And he had been taking, I  
8 believe, ibuprofen just around the clock to try to make his  
9 toe feel better where he had the gout. And then when he came  
10 to see me, we did lab tests, and I had done a physical exam  
11 and prescribed him another type of medicine similar to  
12 ibuprofen called diclofenac. And I'd seen it work better on  
13 other patients. And I told him to stop taking ibuprofen.

14 So they were the same type of medicine. It would be  
15 like taking ibuprofen and Aleve at the same time. He came  
16 back two weeks later for his followup and he was still taking  
17 the ibuprofen and the diclofenac. Those medicines really can  
18 hurt your stomach, cause you to bleed. I've actually seen a  
19 young man in the ICU with a stomach bleed because of taking  
20 too much of those medicine.

21 So it really made me aware -- I was -- I wouldn't  
22 say paranoid, but it really made me aware that patients do not  
23 always listen and follow your directions. So when -- from  
24 that point forward, even at the urgent care, we would  
25 repossess medicine. I think the nurses put them in a

1 biohazard container.

2 But then going forward with patients that are on  
3 long-term products, I discovered through the training programs  
4 there's different ways of maintaining surveillance, and that  
5 became more of an integrated part of my practice once I moved  
6 to Martinsville.

7 Q. Okay. We've talked a lot about it. I don't think we've  
8 gone into detail much. But tell the jury, what are opioids?

9 A. So --

10 THE WITNESS: Is it possible to draw on this,  
11 Ms. Felicia?

12 THE CLERK: Is there something up on the screen?

13 THE COURT: It is possible to draw on it.

14 THE WITNESS: Opioids. Dr. Hail kind of covered the  
15 breakdown between opioids and opiates. But opioids, in  
16 general, are what we classify as narcotic medication. And  
17 there are both legal and illegal forms of opioids or opiates  
18 in the United States. And we use those terms almost  
19 interchangeably. They do have specific meanings, but for our  
20 purposes I think they mean basically the same thing.

21 They're medicine that have been used for, I believe,  
22 around 3,000 years or more for the treatment of pain and other  
23 types of illnesses. They were discovered long ago to alleviate  
24 [phonetic] pain in people with -- among other issues. In the  
25 United States we have certain opioids or opiates that we're

1 allowed to prescribe to help treat certain medical conditions  
2 for patients.

3 But what an opiate does, it acts on the part of the  
4 body called the CNS, or the central nervous system. That's  
5 the main area that it affects. And the CNS stands for central  
6 nervous system. That is your brain and your spinal cord. So  
7 just head and spine, that's the main areas. They affect other  
8 parts of your body, but those are the main two areas that they  
9 affect.

10 And the way that happens, it happens at what we  
11 understand to be the cellular level, so at a very small level  
12 that you can only see under a really good microscope something  
13 like this is occurring. And, I apologize, I'm not an artist.

14 You have what are called synapses. You have a  
15 pre-synapses and post-synapses, and you also have different  
16 inputs. And so what will happen, the reason opiates or  
17 opioids actually work in our body is because we have receptors  
18 for those in our body. And we actually make our own opiates  
19 in our body, or opioids. They're called endorphins. And  
20 endorphins are released when you work out really hard. Maybe  
21 you've heard of "runner's high". Our body under stress  
22 releases those endorphins. And those endorphins come in from  
23 whatever source. They're released in the brain or the spinal  
24 cord or other parts of the body. There's receptors in the  
25 synapses that these endorphins attach to. Those receptors



1 also respond to the opiate or opioid medications. So when  
2 someone takes an opiate or opioid -- remember, they mainly  
3 affect the brain and spinal cord -- those receptors are what's  
4 responsible for the effects of pain relief and any type of  
5 sensation associated with that. And some people, they  
6 experience a great deal of what they call "euphoria" or  
7 "high". That's rare, but that does happen, and it can depend  
8 on what type of opiate they've taken whether they experience  
9 that or not. But these receptors in our body are there, and  
10 they allow us to have these medications used to help treat  
11 various illnesses, including severe chronic pain.

12 BY MR. WILLIAMS:

13 Q. Okay. Now, with respect to -- how does this impact with  
14 tolerance and dependance and stuff like that?

15 MR. RAMSEYER: Your Honor, I didn't hear the  
16 question. Can you repeat the question?

17 BY MR. WILLIAMS:

18 Q. So how does this affect with respect to tolerance and  
19 dependance?

20 MR. RAMSEYER: Your Honor, I think he is allowed to  
21 testify about his practice, but I don't know how much he can  
22 just go into theory. We would object.

23 THE COURT: Well, being he -- are you going to have  
24 him offer expert opinions?

25 MR. WILLIAMS: Your Honor, I can move on.

1 THE COURT: All right. If you would, please.

2 BY MR. WILLIAMS:

3 Q. Dr. Smithers, what was your treatment philosophy?

4 A. So, in that period of time when I moved to Martinsville  
5 and had additional education my treatment philosophy became  
6 that as I would treat the patients that came to me to reduce  
7 or completely remove their immediate-release narcotic as  
8 quickly and as safely as I thought I could while trying to  
9 find an extended-release medication that could better control  
10 their severe chronic pain.

11 And in conjunction with that, I was not just using  
12 narcotics. I was using nortriptyline and medicine in that  
13 class, which specifically can help with nerve pain. They're  
14 not a narcotic medicine. Nortriptyline is in a class similar  
15 to amitriptyline or Elavil. And some people, they do make  
16 people sleepy. In other people, I found that they got better  
17 relief from that than from taking a narcotic. And so that was  
18 one medicine.

19 The other part of what I would do in my diagnostic  
20 workup was a lot of patients suffered from chronic muscle  
21 spasms. So I would work through a variety of different muscle  
22 relaxants with that person to try to find one that gave them  
23 the most benefit and allowed them to improve their function  
24 and improve their quality of life. And at the end of the day,  
25 that was the goal of medication therapy with my patients was

1 for them to have a higher quality of life, be able to sleep at  
2 night, then be able to get up, like Mr. Hartshorn was being  
3 able to testify yesterday, be able to get up and do things and  
4 with life. You know, for all of the bad things that we could  
5 say about the abuse of opiates and opioids, there's a reason  
6 that they're still legal and they're approved by the FDA as  
7 safe and effective for the treatment of severe chronic pain.  
8 It's because they work and they give these patients the  
9 ability to live their lives.

10 Q. Now, Dr. Smithers, if we can, you got over 50 counts  
11 against you regarding over 50 different patients that you're  
12 charged with. What I'd like to do is start going through some  
13 of those patients, if we can here, regarding your treatment,  
14 if we can.

15 MR. WILLIAMS: Ms. Felicia, can we put this up?

16 This is RB-2, 13.

17 THE CLERK: You want these displayed to the jury?

18 THE COURT: Are these documents admitted?

19 MR. WILLIAMS: They're admitted.

20 I apologize. I'm not very technologically savvy.

21 BY MR. WILLIAMS:

22 Q. All right. Dr. Smithers, what I'm going to show you  
23 here, let's look at Robert Battaglia. That's the first person  
24 on the indictment. All right. What I'd like to do is tell  
25 the members of the jury, what is this form?

1 A. So this is a modified new patient intake form for pain  
2 management that I adjusted to -- it's -- I believe this is  
3 page 1 of maybe 28 pages. It's an extensive form that I would  
4 use to have the patients fill out and provide information to  
5 help me better understand the nature of their illness and then  
6 guide our discussion about the medical issues that they had so  
7 that I would be able to understand, you know, what their  
8 complaint was and what type of problems they were suffering  
9 from, as well as hopefully get as much information up front.  
10 So after I reviewed this document and talked to the patient it  
11 hopefully speeds up that process.

12 Q. All right. Now, with respect to Mr. Battaglia, what's  
13 the date that he came into your office?

14 A. I believe it says here September 3rd, of 2015.

15 Q. Okay. Now, what would you have done here with respect to  
16 this as far as the intake with Mr. Battaglia? Walk us through  
17 your first visit with Mr. Battaglia.

18 A. So --

19 THE COURT: Wait. If I can interrupt. What would  
20 you have done? What did you do?

21 BY MR. WILLIAMS:

22 Q. What did you do?

23 THE COURT: Okay. You said, "What would you have  
24 done?" But you mean what he did in fact.

25 MR. WILLIAMS: Correct.

1 THE COURT: All right. Thank you.

2 BY MR. WILLIAMS:

3 Q. What did you do with Mr. Battaglia?

4 A. So he -- at that time I believe my office procedure was  
5 that he would have been handed a clipboard with this document  
6 blank, and he would have filled this document out and then  
7 handed the document in to -- I believe my wife was working at  
8 the front desk at that time, and she would have checked the  
9 form for errors, then I would have had a chance to review it.

10 Q. Okay. And what does it say Mr. Battaglia was complaining  
11 of?

12 A. Looks like he wrote down neck and back.

13 Q. Okay. And when you would see this, what would be your  
14 next -- what's the next thing you did?

15 A. So, I mean, this is the first page that I would review.  
16 It tells you the general complaint that the person has. It  
17 tells you -- and the reason that there's a drawing there, so  
18 that they can mark, you know, and use arrows. And some of the  
19 patients are more descriptive than others in letting you know  
20 where their problem is and where the problem goes to. But it  
21 gives you a guide on what to talk about with the patients.

22 Q. So what would it be -- when Mr. Battaglia came in, what  
23 would be the first thing that would happen when he came in  
24 your office?

25 MR. RAMSEYER: Objection, Your Honor. I think he

1 can ask what happened.

2 THE COURT: Yeah, I'm still not sure I understand.  
3 Is it that --

4 MR. WILLIAMS: I just --

5 THE COURT: Wait a minute. You said that you don't  
6 remember what happened. Are you guessing --

7 What I understood you to ask is what he did. And he  
8 can obviously refer to these records. But he -- and you keep  
9 saying, "I would have done this. I would have done that."  
10 And I don't understand that.

11 MR. WILLIAMS: My apologies.

12 THE COURT: I'm just trying to bring this out for  
13 the jury's knowledge.

14 MR. WILLIAMS: Right.

15 THE COURT: Could you elaborate on your question,  
16 or --

17 BY MR. WILLIAMS:

18 Q. When Mr. Battaglia came in, what was the first thing that  
19 you did in that office?

20 A. So you're referring to when he came back and we had the  
21 examination?

22 Q. Would he have any kind of vitals taken?

23 A. Correct, yes, sir.

24 THE COURT: In other words, Doctor, what I'm  
25 suggesting is you keep saying, "I would have," which sounds

1 like you don't know what you did or you didn't do it but you  
2 should have done it, and I don't think that's what you mean.

3 THE WITNESS: No, sir.

4 THE COURT: So let's don't use "I would have."

5 THE WITNESS: Yes, sir.

6 THE COURT: Let's just refer to what you did --

7 THE WITNESS: Yes, sir.

8 THE COURT: -- based on your recollection and the  
9 records you have in front of you. Okay?

10 THE WITNESS: Yes, sir.

11 THE COURT: All right.

12 THE WITNESS: So I brought the patient back, did  
13 vital signs and immediately -- and one of the reasons I did my  
14 own vital signs typically was so I could start the interview  
15 process with the patient as I did their vital signs. I  
16 could -- also, there's certain things you could learn. I  
17 learned as a nurse aid and EMT there's certain things you  
18 could observe, involuntary movements and things when you do  
19 vital signs yourself for your patient. And I also trusted  
20 myself to do vital signs more than anyone else, so that was  
21 the other reason I did it that way.

22 After I did the vital signs, I would immediately sit  
23 down with the document and begin questioning the patient. Or  
24 I did sit down and go through the forms that he completed and  
25 spoke with him in regards to his chief complaint and would

1 attempt to get more information specifically to the cause.  
2 And typically I would write that on this page. It doesn't  
3 appear that that happened in this case, but that was what this  
4 first page would be used for.

5 BY MR. WILLIAMS:

6 Q. All right. Now, what did -- what did Mr. Battaglia state  
7 was wrong with him and how he was hurt?

8 A. So I believe the first time I saw Mr. Battaglia was  
9 actually in West Virginia at my other office. And this looks  
10 like what he complained of often, specifically from a car  
11 accident that he had suffered ten years prior. He complained  
12 of severe chronic pain in his neck and low back. And he often  
13 complained of the pain radiating from his neck to his low  
14 back, or from his low back up into his neck. And this can be  
15 common with different types of nerve compression injuries that  
16 people suffer in car accidents frequently.

17 Q. Okay. And did Mr. Battaglia relate to you that he had  
18 been in a motor vehicle accident?

19 A. He did, yes, sir.

20 Q. And what physical things did you do with Mr. Battaglia?

21 A. So I would have done -- or I did do range of motion  
22 testing. Specifically, where the patient -- it's called a  
23 focused physical exam. So you focus on the areas where the  
24 patient is saying they're having the most difficulty or they  
25 have the most pain. And the idea from my training and



1 experience was that you -- if they did have what we call  
2 radiculopathy, if they have nerve pain or shooting nerve pain,  
3 you could get to that issue much quicker by doing a focused  
4 physical examination where you measure or have them do range  
5 of motion against resistance. If it's someone's head and  
6 they're complaining of neck pain, you can have a hand on  
7 either side of their face and turn against resistance. If  
8 that produces the response of normal reaction, sometimes they  
9 have the normal response of muscle reaction. They also have  
10 or complain of a shooting pain into their arm, or they can  
11 complain of shooting pain into their opposite arm. So  
12 that's -- those are the types of physical manipulation  
13 maneuvers I did on Mr. Battaglia.

14 Q. Okay. What objective determinations did you make  
15 regarding Mr. Battaglia?

16 A. Based on my past medical history, past medication  
17 history, and physical examination, I determined that he was  
18 in -- he lived in daily chronic pain.

19 Q. Okay. And that was based on what all decisions that you  
20 made?

21 A. My determination was --

22 Q. Yeah. What all factors did you use to come to that  
23 conclusion?

24 A. That he -- well, I trusted the patient. I believed that  
25 he was telling me the truth. And then his physical

1 examination at the time corresponded with the complaints that  
2 he had indicated on his chart. And I used my training and  
3 experience and knowledge of treating these types of conditions  
4 hundreds of times up to this point in my career that he  
5 definitely suffered from these medical ailments.

6 Q. Okay. And did you consult any outside information such  
7 as MRIs? X-rays?

8 A. In Mr. Battaglia's case, I would have to be refreshed on  
9 his chart to see what other records existed. Typically that  
10 is what I preferred to do is rely on other medical records.  
11 That's very helpful.

12 MR. WILLIAMS: Okay. Let's stop right here just a  
13 second. If we could push this back up.

14 THE CLERK: Turn it back on?

15 MR. WILLIAMS: Yes, please.

16 BY MR. WILLIAMS:

17 Q. Okay. Now, what I'm asking you is what is this form  
18 right here that you were using?

19 A. So this would typically be -- or this was the last page  
20 in the chart where I would spend most of my time taking the  
21 findings on physical examination, using the drawings, which in  
22 my training and experience was common that this is how this  
23 was notated on paper. And I would also -- so I did not just  
24 accept what she, the patient, wrote down. Oftentimes, the  
25 patients were confused, even on the zero-to-ten pain scale.

1 So I would go over that scale in my own way with the patients.  
2 And the way I would explain the zero-to-ten pain scale, which  
3 everybody is familiar with, I think, I would say zero is no  
4 pain at all and 10 is the pain of death or ten is, you know,  
5 the most severe pain you've ever experienced in your life,  
6 just to try to give the patient a reference point as to what  
7 that actually was. And then I would go through the questions  
8 on this form with the patient.

9 It looks in this case that my wife went through  
10 those questions and did the vital signs herself, actually.  
11 But, typically, I was the one performing all the work on this  
12 page specifically.

13 Q. And what I want to do is circle this right here. Right  
14 below his name, what are those codes?

15 A. So those are -- as Dr. Bassam testified to yesterday,  
16 those are ICD codes. It's from the international coding  
17 diagnosis manual. I believe those are the ICD-9 codes. And  
18 by October of 2015, just a month after this, I think we  
19 changed to ICD-10. But these codes, these numbers, they  
20 correspond with actual diagnoses.

21 So the first code that he has there, 338.21, that  
22 corresponds with severe chronic pain due to trauma. The way  
23 we think about trauma in medicine is if your chronic pain was  
24 caused by a motor vehicle accident, or was caused by a coal  
25 mine collapse, or was caused by domestic abuse, then that is

1 trauma. You suffered trauma. So that would be the cause --  
2 or the primary cause of your severe chronic pain.

3 There can be additional causes. I think in  
4 Mr. Battaglia's case, it wasn't helped by the fact that he sat  
5 in cars and drove as a salesman from California to everywhere  
6 and was sitting for long periods of time. I think that  
7 contributed greatly. His primary cause of chronic pain was  
8 trauma.

9 MR. WILLIAMS: Ms. Felicia, you might turn that off.  
10 Is there a way I can do that?

11 THE CLERK: You might have a box. I don't think so.

12 MR. WILLIAMS: Your Honor, if I can have her place  
13 that back up again, please.

14 BY MR. WILLIAMS:

15 Q. This is in Mr. Battaglia's file, but what is this right  
16 here?

17 A. So this would be the -- excuse me. This would be the  
18 Brief Pain Inventory (Short Form). This was another form that  
19 I used on every follow-up visit after the initial visit to,  
20 again, monitor the status of the patient as far as their  
21 control with the motions we were using and other interventions  
22 I'd recommended to the patient. This was a way to keep track  
23 of if there was improvement or if things were staying the  
24 same, or if, you know, they had a better month. And if we  
25 changed a medicine the previous month, this was a way to see

1 and have documentation by the patient that they experienced  
2 improvement from the medication change we made the prior  
3 month. So that was the significance of this document.

4 Excuse me, the other significant element to this  
5 document is the ability for the patient to document any side  
6 effect they were having to the medicine. Then that would  
7 allow me to discuss side effects they had to the medicine and  
8 to potentially make changes, like in Ms. Fisher's case where  
9 we decided to make a change to her medicine because of the  
10 side effects.

11 Q. Okay. Now, this would state for the patient to point out  
12 where the injuries were; is that right?

13 A. If you could scroll down just a little bit.

14 Yes.

15 Q. I mean on the body. I'm talking about on the body.

16 A. Oh, yes. On the mannequin there, that is just an  
17 opportunity, again, for the patient to indicate if they had  
18 any new injuries, if they had any, you know, current issues  
19 that were worsening or improving and where those would be  
20 located on the body.

21 Q. Okay. As we scroll down it talks about your worst pain  
22 and least pain in the past 24 hours; is that correct?

23 A. Yes, sir.

24 Q. And this would be a document that the -- that they would  
25 fill out or that you would fill out?

1 A. No, this would be a document the patient was supposed to  
2 fill out.

3 Q. Okay. And then I think it says, "Describe your average  
4 pain," Number 5. Is that right?

5 A. Yes, sir, that's correct.

6 Q. And the pain right now in Number 6?

7 A. Correct.

8 Q. And then what treatments you're receiving for your pain?

9 A. Correct.

10 Q. Why would all these things be necessary to make a  
11 determination?

12 A. Well, because each visit we are -- we want to know how  
13 they're doing in response to the treatment. I mean, this  
14 is -- I found it to be an effective way to -- with honest  
15 patients, I found it to be an effective way to monitor their  
16 response to therapy.

17 Q. "With honest patients," what are you talking about?

18 A. I am referencing the fact that within the first six  
19 months of -- to a year of practice I learned several lessons  
20 the hard way about trusting people that I should not have  
21 trusted.

22 Q. Okay. Did you implement anything at your practice during  
23 this time period to try to stop this?

24 A. I did. I was approached by a gentleman named Mark  
25 Radcliff who operated the company, I believe PPPFD,

1 Physicians, Patients, and Pharmacists Fighting Diversion, and  
2 he offered one of his compliance managers, as I understood it  
3 at the time, Mr. Wendell Wilson, who had prior law enforcement  
4 experience on a narcotics task force. And we -- he and I  
5 discussed what type of services he provided as far as  
6 accountability and monitoring the patients. That was  
7 something I definitely thought I needed more in my practice.  
8 That, you know -- so as soon as -- I think as early as  
9 September or October of 2015 he began to work in my office.

10 Q. Okay. And that would be Wendell Wilson; correct?

11 A. That would be Wendell Wilson, yes, sir.

12 Q. What did Wendell do? What was his role?

13 A. So Wendell, he wore many hats. But his primary -- his  
14 primary role was that of a compliance manager. And so -- and  
15 the reason that it made sense to me to employ someone like  
16 this was I had trained with physicians who at times were  
17 really rude to patients and yelled at them and berated them,  
18 you know, even in some cases cursed at them. And I -- my  
19 approach to patient care was that I wanted to develop a  
20 relationship with the patient to be able to see them on each  
21 visit and honestly be able to assess their status. For me it  
22 was difficult to have kind of a policeman function compliance  
23 with them and be their physician and trust them and try to  
24 treat them at the same time.

25 And so Mr. Wilson, he being former law enforcement,

1 he had a much more direct approach about him. And so he --  
2 you know, he would help. He would do the urine drug screens  
3 and he would monitor the patients for, you know, pill count  
4 and different things like that, needle marks, track marks. He  
5 would go through -- he had a couple different forms that he  
6 went through. I think he had an initial form that was pretty  
7 extensive where he went through patients' depression, suicidal  
8 risk, and any drug abuse history, any forms of drug abuse.  
9 And that was also a helpful screening tool. He also ran  
10 criminal background checks. And this was all provided under  
11 that company, the Physicians, Patients, Pharmacists Fighting  
12 Diversion he was employed through. And it -- to me, it  
13 provided a service hopefully I was only going to be treating  
14 patients I could trust.

15 Q. Okay. Now, did he also conduct the pill count and stuff  
16 in your office, too, or was that someone else in your office?

17 A. No, he would have done that as well.

18 Q. So a person comes into your office. They would check in  
19 at the front desk; is that right?

20 A. Yes.

21 Q. And then after you hired Wendell, the next person they  
22 would see would be Wendell?

23 A. Yes, sir, that's correct.

24 Q. And that's when Wendell would take them back through the  
25 pill count, through the drug testing and all like that. And



1 then would the patient go back out and wait, or would the  
2 patient then immediately come to you?

3 A. So we tried a few different approaches to try and  
4 streamline the process. I mean, we really had more exam  
5 rooms. I think we had ten exam rooms in that office. I think  
6 the way we tried that worked the best was Wendell, when he  
7 finished with the patient, he would put them in an exam room,  
8 put their chart next -- in the holder next to the door, and  
9 then he would let me know that the patient was ready to be  
10 seen.

11 Q. Okay.

12 THE COURT: Excuse me, Mr. Williams. I think it  
13 would be appropriate to stop for lunch at this time.

14 I have another matter that I need to take up in a  
15 different case. And so what I'd like to do is just end your  
16 examination right now and allow the parties and the jury to go  
17 to lunch and come back at 1:00. All right?

18 MR. WILLIAMS: Okay. Thank you.

19 THE COURT: So, ladies and gentlemen, I'm going to  
20 let you go to lunch a little early now. If you'll be back at  
21 1:00, that way you won't have to wait while I take up another  
22 matter. So if you'll follow the bailiff out, please.

23 (Proceedings held in the absence of the jury.)

24 THE COURT: All right. Ladies and gentlemen, we're  
25 going to take a short recess. And in this case we'll

1 reconvene at 1:00.

2 All right. We'll be in recess.

3 (Proceedings suspended at 11:34 a.m. and resumed at 1:00  
4 p.m.)

5 THE COURT: Are we ready for the jury, Mr. Williams?

6 MR. WILLIAMS: Yes, Your Honor.

7 THE COURT: All right. Dr. Smithers, if you'd  
8 retake the stand, please.

9 We'll have the jury in.

10 (Proceedings held in the presence of the jury.)

11 THE COURT: All right. We're ready to go again.

12 Mr. Williams, you may proceed.

13 BY MR. WILLIAMS:

14 Q. Okay. Dr. Smithers, if I can, let's go -- if we can show  
15 up what I've got on my screen here. We'll start with Robert  
16 Battaglia. What I'd like to do is sort of scroll through this  
17 here a little bit. I'll try to go real slow. What I'd like  
18 for you to do is just sort of tell us what you see here with  
19 respect -- what you did with Mr. Battaglia, what he presented,  
20 and what you diagnosed him with.

21 MR. RAMSEYER: Your Honor, I'm going to object. Of  
22 course --

23 THE COURT: Didn't you already go through Dr. --  
24 this patient?

25 MR. WILLIAMS: I don't think we got completely

1 through it. I was going to scroll on through a little bit  
2 more, but if I can have just a little bit of leeway,  
3 Your Honor.

4 THE COURT: Okay.

5 THE WITNESS: Yes. What we discussed about  
6 Mr. Battaglia on the first page here is correct and supported  
7 the objective findings I found on physical examination and  
8 further discussion with the patient in the patient interview.

9 BY MR. WILLIAMS:

10 Q. What did Mr. Battaglia present with? What was his  
11 injuries?

12 A. He, he was favoring his -- I believe he was favoring his  
13 right side. He had significant pain, even to palpation, I  
14 believe, in his neck. And on range of motion in his lower  
15 back, he had some shooting pains into I believe his right side  
16 as well, into his right leg.

17 Q. Okay. Now, as we scroll through here just a little bit,  
18 did he indicate he had been involved in a motor vehicle  
19 accident?

20 A. Yes.

21 Q. Okay. What else did he indicate he had been involved  
22 with?

23 A. Most of the significant injury he had suffered was as a  
24 result of a motor vehicle accident. He indicated to me that  
25 that pain had -- this is common with some types of chronic

1 pain that it had -- and I've been in a car accident. I've  
2 been in a couple car accidents myself. Sometimes you have an  
3 initial phase that you go through where you feel better and  
4 then things kind of settle down in your body and get worse.  
5 And I believe that he was in that phase of dealing with this  
6 issue where his pain was worsening and his symptoms were  
7 getting worse.

8 Q. Okay. What symptoms and stuff was he suffering from?

9 A. He was suffering from severe chronic pain. He had, you  
10 know, limited range of motion in his neck due to pain. On a  
11 physical examination, he suffered from limited range of motion  
12 in his low back due to, again, pain with certain extremes of  
13 movement. When you have -- and this is common if you have any  
14 type of impingement of nerves or if your back's ever gone out  
15 on you, if you move a certain way or feel a sharp pinch, that  
16 can -- sometimes we can elicit that or we can draw that  
17 symptom out on physical examination when we put you through a  
18 certain range of motion in your low back or in your neck. We  
19 can get that -- we can reproduce that objective finding of  
20 shooting pain in some cases.

21 Q. Okay. Based upon your -- based upon your examination,  
22 based upon what he told you, did you feel like he had a  
23 legitimate pain?

24 A. Yes. Based on my objective findings through physical  
25 examination, verbal examination of his past medical history

1 and documentation I had at the time, yes, he was diagnosed  
2 with severe chronic pain due to trauma, among other diagnoses  
3 that indicated he had legitimate medical need to be treated.

4 Q. Okay. What I'm showing on the screen here should be  
5 RB-269. What is this a copy of?

6 A. This appears to be a copy of the discharge letter that I  
7 drafted and mailed to Mr. Robert Battaglia.

8 Q. Okay. And why did you discharge Mr. Battaglia?

9 A. I received information, as sometimes happened at my  
10 office. I think pretty much every doctor's office I've ever  
11 worked in, patients tell you things. But I received  
12 confidential information that he had been treated at a  
13 methadone facility previously. And in reviewing the records  
14 that we had in the office, he had never indicated that he had  
15 received such treatment. And that's something that we  
16 routinely screen patients for and ask them if they had had  
17 those types of therapies.

18 There were several other statements he had made that  
19 did not add up and that were not consistent with other  
20 documentation I was able to find.

21 Q. Okay. I'm going to show you, if I can back up here,  
22 to -- should be RB, page 64. What is this of?

23 A. This is another Brief Pain Inventory (Short Form) of  
24 Mr. Battaglia's visit on September 10th -- I'm sorry. That's  
25 his date of birth -- on April 11th, 2016.

1 Q. Okay. And what would this short form be -- I know we  
2 described generally what it is, but this is sort of an interim  
3 type thing where he would repeat. Is that what it is?

4 A. Correct. Usually the goal was to see a patient every  
5 month, every 30 days, roughly, to -- and that was not what was  
6 required. It wasn't my understanding of what was required in  
7 regards to the types of treatment that these patients were  
8 receiving with controlled substances. You know, they could  
9 have been seen on a 90-day --

10 MR. RAMSEYER: Objection, Your Honor. I think he's  
11 going to -- if he's saying what's required, I don't think he  
12 necessarily is an expert on that.

13 THE COURT: I'm not sure I understand the objection,  
14 Mr. Ramseyer.

15 MR. RAMSEYER: He said -- he's saying his  
16 understanding of what is required.

17 THE COURT: Yes, sir.

18 And the basis of your objection?

19 MR. RAMSEYER: I mean, if he wants to limit it to  
20 that's what he -- if he wants to say that's what he thought,  
21 that's fine, but I don't think he can say what's a fact in  
22 terms of what's required.

23 THE COURT: Well, where did you get this information  
24 that this was required?

25 THE WITNESS: This was through my training and

1 practice in hospital residency training, internship training,  
2 and working with other physicians.

3 THE COURT: I mean, when you say "required," you  
4 mean by law or just you felt that that was a good practice?  
5 Or --

6 THE WITNESS: Well, no, Your Honor. I mean, I --  
7 we -- I don't know any physician that's actually trained on  
8 the Controlled Substances Act. We kind of learn by osmosis.  
9 We learn by training with other physicians. And that's how I  
10 came to understand the 90-day rule.

11 THE COURT: All right. Well, I'm going to overrule  
12 the objection. Go ahead.

13 BY MR. WILLIAMS:

14 Q. Now, Dr. Smithers, if you will, this is a note at the  
15 bottom of that. What does this note say?

16 A. So this would first be starting with the subjective  
17 information from -- information from the patient. This is  
18 what the patient reported to me, Mr. Battaglia being the  
19 patient. "Patient takes and tolerates medication RX,"  
20 prescription medication, "well with," S with a line over it,  
21 "without issues. Patient reports increased driving due  
22 to," D/T "due to work. Now," C with a line over it, "with  
23 1,000 to 1500 miles per week. He anticipates at least two  
24 more months of driving this much due to work. He reports  
25 increased right leg pain," with up arrow, "that begins in his

1 low back and radiates to his toes. Patient states the  
2 radiating, aching, burning pain with numbness is worse with  
3 sitting."

4 Q. Okay. And what does the next section say? It's got a  
5 bunch of letters and numbers. What are those?

6 A. Correct. So the next section, "A/P," is assessment/plan.  
7 And then those numbers are the ICD codes for the diagnoses  
8 that I have diagnosed Mr. Battaglia with.

9 Q. Okay. Do you recognize those codes?

10 A. Yes, sir.

11 Q. What are they?

12 A. So G89.4 would be chronic pain syndrome. G892.1 would be  
13 severe chronic pain due to trauma. N54.5, I believe that is  
14 low back pain. M54.16 would relate to that. M62.838 and  
15 appears 54.16 is listed twice. M.79.2, that may be a  
16 radiculopathy. I would have to look and see.

17 Q. Okay. And what else does the remainder of the note say?

18 A. It describes the plan. "Patient was given extensive  
19 guidance regarding posture and postural support while driving.  
20 He will be acquiring health insurance within the next few  
21 months, hopefully, and better able to afford a new MRI of his  
22 low back. Blood work, including testosterone levels,  
23 T-levels. And we increased his extended-release long-acting  
24 medication. We decreased his immediate-release pain  
25 medication. Patient reports not taking his Neurontin the past



1 four to five months and has supply at home. He will resume  
2 now taking it at nighttime." QHS is at bedtime. "And three  
3 times daily once adjusted to prescription. Continue on  
4 current prescriptions as written," is what that last line  
5 stands for.

6 Q. Okay. We'll skip down to page 80. I'm going to show you  
7 what is RB-2-80. What do you see here? What is this right  
8 here? If you can, if you would tell the jury.

9 A. So this would be a copy. The types of prescriptions I  
10 used I believe were the most secure at the time, and they  
11 transferred -- without a piece of carbon paper in there, they  
12 transferred the handwriting onto the initial page onto a  
13 second page behind that. And so this is a carbon -- what we'd  
14 call a carbon copy of that prescription.

15 Q. Okay. And does it have anything on there regarding codes  
16 of any type?

17 A. Yes. It was my habit to put the diagnosis code.  
18 Typically, I would put three of their diagnosis codes, but in  
19 this case it was just one. I believe that's the G89.1, severe  
20 pain due to trauma diagnosis code.

21 Q. Okay. So that was actually on your prescription?

22 A. Correct, yes, sir.

23 Q. Were you required to do that?

24 A. I was not.

25 Q. Okay. If we can, we're going to move to Frank Blair.

1 This would be F. Blair 1-21.

2 Okay. What are we seeing here?

3 A. This is what's called a super bill. Pretty much every  
4 medical office or even hospital you go to, but especially a  
5 clinic, has some type of what's called a super bill. And it  
6 just allows whoever is treating the person, whether it's a  
7 nurse, nurse practitioner, physician's assistant, doctor, at  
8 the end of the visit it allows them to circle or mark what --  
9 basically using these codes, mark what they did and then  
10 indicate, you know, what types of diagnosis they were treating  
11 in that visit.

12 Q. Okay. And so this would have, actually, diagnosis codes  
13 on it; correct?

14 A. Yes, sir. These are a menu of diagnosis codes here.

15 Q. Okay. What does it state that these -- or having  
16 complaints with?

17 A. In the case of Mr. Blair, he appears to suffer from  
18 diagnosis of headache, which I believe was recurrent. He also  
19 suffered from osteoarthritis in 19.9. And M62.838 would be  
20 muscle spasms. And G89.21 would be severe chronic pain due to  
21 trauma. G89.4 would be chronic pain syndrome. And M54.10 and  
22 M54.5, those would be related to radiculopathy. And it may be  
23 unspecified, but that would be radiating pain or shooting  
24 nerve pain.

25 Q. Okay. Now, with respect to Mr. Blair, what is this

1 again?

2 A. So this is Mr. Blair's Initial Pain Assessment Tool that  
3 was completed on his first visit.

4 Q. Okay. And if I'm circling right here, what would that  
5 be?

6 A. It appears his vital signs.

7 Q. Okay. That would be what? Blood pressure?

8 A. Blood pressure, yes, sir; 122 over 82, pulse rate or  
9 heart rate of 85; oxygen saturation 97 percent; and a weight  
10 of 175.8 pounds.

11 Q. Okay. And what would these right here be again?

12 A. Those would be the diagnoses that I've diagnosed  
13 Mr. Blair with on that office visit.

14 Q. Okay. And do you recall what those are?

15 A. Those are the earlier diagnosis code systems. So this --  
16 these are ICD-9 codes. The codes we were just looking at are  
17 ICD-10. Which this is, in September of 2015, it's right  
18 before the transition to ICD-10.

19 These diagnosis codes would reflect similar  
20 diagnoses to what we just looked at on the super bill for this  
21 patient. 338.21 is severe chronic pain due to trauma. I  
22 believe 724.4 and 724.2 have to do with radiculopathy or  
23 radiculitis, neuritis, nerve pain.

24 Q. When Mr. Blair came in, what kind of examination did you  
25 do on him?

1 A. So Frank Blair, he suffered a number of different  
2 injuries, the most significant of which involved some head and  
3 neck trauma due to an ATV accident when he was younger. He  
4 was out driving, and he lived in a -- kind of lived in a  
5 holler up in West Virginia. So he was out driving his ATV and  
6 he came around the corner, and another vehicle in a truck, a  
7 neighbor in a truck, came and I think basically hit him head  
8 on.

9 MR. RAMSEYER: Your Honor, the only objection I'd  
10 make is just I think he can testify to what Mr. Blair told  
11 him, I don't think he can testify that that's what happened.

12 THE COURT: Yes, sir. You're testifying to what he  
13 told you. You don't -- you didn't witness the accident or  
14 anything like that?

15 THE WITNESS: No, Your Honor.

16 THE COURT: Well, you need to make clear what you're  
17 being told and what you know of your own knowledge.

18 THE WITNESS: Yes, sir.

19 THE COURT: All right. Thank you.

20 THE WITNESS: So this is based on what the patient  
21 told me. He was thrown from the ATV and had multiple  
22 fractures in his head and neck as a result of this accident.  
23 And as a result of this, he ended up on permanent disability  
24 at a very young age.

25 ///

1 BY MR. WILLIAMS:

2 Q. Did you do any objective tests on him?

3 A. Yes, sir.

4 Q. What did you do?

5 A. Again, with the reported history of neck and upper back  
6 and lower back issues, there was range of motion testing.  
7 There was palpation, which is -- palpation is just where we  
8 are trained to feel. You know, when we touch the human body  
9 in certain areas, we're trained to be able to assess what  
10 we're feeling and, you know, determine based on that.

11 So, typically, I would be doing palpation while I  
12 was doing range of motion so that if there was pain in a  
13 certain area of motion -- so if I'm holding at the top of his  
14 head and I'm moving his head in certain planes, side to side,  
15 forward, backward, and I'm feeling his neck at the same time,  
16 I am trying to understand if his muscles are responding the  
17 way they're supposed to respond to that movement. And then  
18 whenever I have him try to move his head in resistance to my  
19 hand, I'm also doing the same thing to try to assess if he has  
20 full range of motion, or if he has certain types of pain, or  
21 if he has those types of pain if they're legitimate or if  
22 they're not legitimate.

23 It's a very effective way at assessing not only the  
24 underlying cause, potentially, of a structural problem or a  
25 nerve damage or if a person is experiencing a disk that's

1 compressing a nerve, it's also helpful, I believe, to see, you  
2 know, if the patient has the full range of motion capacity and  
3 then be able to evaluate their functional capacity based on  
4 that exam.

5 Q. Okay. I don't want you to go through all of this because  
6 we're going to try to speed it up. I know everyone is kind of  
7 wanting to move along. As we go through this initial  
8 assessment, describe some of these things that they fill out  
9 and why it's important for you to know.

10 A. So when I'm evaluating a patient and wanting to better  
11 understand how their problems affect their daily quality of  
12 life, I adjusted this form and used it because it gave me a  
13 lot of information. As I would go through this form with the  
14 patient on their first visit, it would give me a lot of  
15 information in regards to therapies they had tried before,  
16 therapies they hadn't tried before. In this page  
17 specifically, you know, "Check all of the following that  
18 describe your pain." It gave me something to conversate  
19 (sic), to talk with them about, as far as what types of  
20 symptoms they had as a result of the chronic pain they lived  
21 with.

22 Q. Okay. I think this would -- this section here just  
23 basically says, "Mark what increases your pain or decreases  
24 your pain." Is that correct?

25 A. That is correct.

1 Q. Okay. And that would be doing things such as bending,  
2 lifting, standing, those type things; correct?

3 A. Yes, sir.

4 Q. Okay. And then I think, "Associated symptoms, numbness,  
5 tingling." Why is that important?

6 A. So with different types of nerve compression and nerve  
7 injury, especially if you think about someone who's thrown off  
8 of a four wheeler in a head-on collision with a vehicle, some  
9 things heal over time and get better. Some things may not.  
10 And numbness, tingling, and as you move down there, weakness  
11 and balance, it's going -- it's assessing what type of  
12 external deficits that person may continue to be living with,  
13 and it's giving me a clue on what to talk to them about and  
14 ask further questions to better understand their functional  
15 capacity as well as, actually, their -- the level of pain that  
16 they live with on a day-to-day basis.

17 Q. Certainly treatments that have worked and not worked,  
18 that's a part of this section, isn't it?

19 A. Yes, it is.

20 Q. Okay. And then certainly whether or not they've had MRIs  
21 and X-rays and those type things; correct?

22 A. That is correct, yes.

23 Q. Now, as we go through, this section here would be telling  
24 you what?

25 A. So this is a really important part of this document of

1 the whole chart. You'll frequently see my handwriting here  
2 because when I would go over this part of the document, I  
3 filled out medical charts in doctors' offices before. I'm  
4 sure all of us have. There are things you forget or things  
5 you don't think of. This was a really important thing for me  
6 to know what medicines and, right above this, what other  
7 therapies have been tried. I believe it's the page before  
8 this -- and what's worked and what hasn't because that was a  
9 way for me to understand what type of benefit they had  
10 received from previous therapies, what other doctors have done  
11 that have helped, and what other doctors have done that  
12 haven't helped.

13 Q. Okay. So you have social histories, things such as  
14 family history. That's just to be able to make a better  
15 assessment; is that correct?

16 A. Yes. Again, understand their social situation. And it  
17 was really important to me to try to understand as much about  
18 their situation outside of my office as possible.

19 Q. Okay. Now, on page 109, I'm going to ask you to go over  
20 this real quick. I promise, ladies and gentlemen, we're not  
21 going to go through it on every one. I just want to go over  
22 it once so we understand. What is this document right here?

23 A. So this is a screening tool that we use. And the --  
24 there's a variety of different screening tools that have been  
25 developed over, I would say, the past 30 to 40 years for pain



1 management and to assess different aspects of that patient,  
2 you know, whether they're going to abuse their medicine,  
3 whether they're going to be compliant and take medicine the  
4 way it's prescribed.

5 This is one of the -- as it was presented to me,  
6 this was one of the best research tools. From a screening  
7 standpoint, it had been verified as being one of the best  
8 tools to accurately indicate the patient's likelihood of not  
9 using their medicine appropriately.

10 Q. It was a two-page document; is that correct?

11 A. Yes, sir, 24 questions.

12 Q. So what is this right here?

13 A. So this is the standard agreement that patients were  
14 required to understand and sign at the beginning of any type  
15 of opioid maintenance therapy. Whether they had cancer or did  
16 not have cancer, this was the document -- I typically read  
17 through this document with the patient so that they -- so that  
18 there was no confusion. And many of the practices I had in my  
19 office were designed to minimize confusion that the patient  
20 could have about what we expected in terms of compliance.

21 Q. Okay. And I won't go over it -- get you to go over it.  
22 I think the jury has certainly heard and could read anything  
23 with that. One of the things that's been brought up is a lot  
24 of times the pharmacy stuff was not filled out. What would be  
25 the reasons pharmacy stuff would not be filled out?

1 A. In certain cases, you know, these severe chronic pain  
2 refugee patients that came from other states, they -- and I  
3 believe especially Kentucky had this problem from the  
4 standpoint of the patient -- they have lost their provider,  
5 and in many cases the pharmacy, because of the way the state  
6 of Kentucky chose to approach this issue. There were a lot of  
7 pharmacies in Kentucky that were shut down. So patients, a  
8 lot of times, didn't have a pharmacy at that time. So we  
9 would go back -- and the fact -- I think that document there  
10 showed it. We went back and changed the pharmacy because the  
11 patient changed pharmacies. But there were times where a  
12 patient just didn't have a pharmacy and we would, you know,  
13 enter that information. And later, sometimes that information  
14 did not get entered in.

15 Q. Okay. Now, let's move on, if we can, to Steven Blevins.  
16 Okay?

17 A. Okay.

18 Q. And we're going to try to go a lot faster with these, not  
19 go through all these documents.

20 What do you see here with Steven Blevins?

21 A. So he had a few different issues going on. And it would  
22 appear, based on how I numbered those issues in the document  
23 here from a -- after my physical examination, he mainly  
24 suffered from lower left leg problems and chronic pain from  
25 that issue, in addition to low back and mid back between the

1 shoulder blades, chronic pain issues with that as well and  
2 more so on the right side as opposed to the left.

3 Q. Okay. And these would be what the diagnosis codes would  
4 be with respect to that?

5 A. Yes, sir. Those would be the ICD-9 diagnosis codes.

6 Q. Okay. Did you have occasion to -- did you do a thorough  
7 exam on Mr. Blevins?

8 A. Yes, sir. And my objective findings indicated that those  
9 diagnoses were appropriate and that he was -- he had  
10 legitimate medical need to be treated for his chronic pain  
11 issues.

12 Q. Okay. And I'm going to show you what is page 2, SB-2.

13 A. Correct.

14 Q. And that is the first page of the pain assessment.

15 A. Yes, sir.

16 Q. And that indicates he was involved in a motorcycle  
17 accident.

18 A. Correct, yes, sir.

19 Q. Okay. And based upon your examination and everything,  
20 did you believe he had a legitimate need?

21 A. Absolutely, yes, sir.

22 Q. Okay. If we can, let's move to Geneva Bowman.

23 Okay. Page 41 of Geneva Bowman. What do you see  
24 with respect to Geneva Bowman?

25 A. So Ms. Bowman, she suffered from a variety of issues.

1 Her most significant issue was in her low back and left hip.

2 Q. What did you do with -- what are those diagnosis codes?  
3 Do you recall?

4 A. The -- those are the ICD-9 diagnosis codes. I have not  
5 used those diagnosis codes since the fall of 2015, so those --  
6 I mean, if memory serves me, those are related to chronic pain  
7 and, you know, nerve radiculopathy, shooting pains, things of  
8 that nature which do correspond to the physical exam document  
9 there.

10 Q. Okay. Did you conduct a physical exam on Ms. Bowman?

11 A. Yes, sir.

12 Q. Did you always conduct a physical exam on --

13 A. Yes, sir.

14 Q. Now, looking here at the initial pain thing, what is it  
15 that Ms. Bowman was complaining of? What did her injury --  
16 what did she tell you her injury resulted from?

17 A. Well, she indicates here that she had a severe fall. And  
18 I believe she was trying to indicate a stress fracture. This  
19 caused two fractures in her neck, FX, apostrophe S, fractures,  
20 and it was due to a work-related accident, traumatic fall  
21 while working in a factory. In the process of that she also  
22 injured her left hip. And she reported at that time that she  
23 had been on permanent disability.

24 Q. Okay. Anything else about Ms. Bowman that you recall?

25 A. She had multiple issues. And this is kind of a common

1 situation, as the previous form indicated. So you know, when  
2 her initial injury occurred, when the fall occurred, the  
3 fractures in her neck were the biggest problem she was facing  
4 at that time, but then she also hurt her left hip. Then over  
5 time the left hip became more of an issue for her than the  
6 neck. That's a pretty common situation where when someone has  
7 multiple injuries in an accident, one injury can linger and  
8 get worse over time.

9 Q. All right. Did you believe she had a legitimate need,  
10 medical need?

11 A. Based on my objective findings, she definitely had a  
12 legitimate need to be treated.

13 Q. Do you feel like that continued throughout your  
14 treatment?

15 A. Yes, absolutely.

16 Q. Go to Jason Bowman.

17 A. Can I clarify on Geneva Bowman?

18 Q. Yes.

19 A. So when I say, "legitimate medical need existed," in some  
20 of the -- in most of these patients I believe that we're  
21 looking at, they were discharged, ultimately. And as Mr. Tom  
22 the pharmacist mentioned earlier, legitimate medical need can  
23 exist even when a person has a problem with taking opiate pain  
24 medication. They can still have chronic pain. They can still  
25 have cancer. They can still suffer tremendously. So that was

1     why I worked very hard to have as organized of a discharge  
2     process as possible over time. I didn't start out with that,  
3     but I would say we could determine at what point they were no  
4     longer candidates to receive opiate therapy.

5             THE COURT: Well, when you say "discharged," you  
6     mean when you terminated them?

7             THE WITNESS: Right. When the doctor-patient  
8     relationship was terminated due to noncompliance.

9             THE COURT: All right.

10    BY MR. WILLIAMS:

11    Q. Now, if I can, let's move to Jason Bowman.

12    A. Yes, sir.

13    Q. This is his Initial Intake Form; is that correct?

14    A. Yes, sir, does appear to be.

15    Q. This would be what he filled out and provided to you?

16    A. Correct.

17    Q. Okay. What does it say that his injuries are a result  
18    of?

19    A. It appears, my handwriting toward the bottom of the page,  
20    that he -- so he filled out the form and then I -- as I was  
21    saying earlier, on the direct patient interview that I did  
22    with him, this is commonly what I would do is try to get more  
23    information to understand the initial cause of their severe  
24    chronic pain. And, in his case, he had a motor vehicle  
25    accident in 2012, suffered -- reported suffering two neck

1 fractures, upper back strain/sprain. And that was believed to  
2 be a source of nerve damage in his lower back.

3 He had also suffered -- this was common for several  
4 of the patients I'd saw. He suffered two mining accidents  
5 working in underground coal mines. One of those was a --

6 MR. RAMSEYER: Again, I just want to note my  
7 objection. He's saying that he did suffer a mining accident.  
8 I think the correct answer is the patient told me that.

9 THE COURT: Is that correct?

10 THE WITNESS: Yes, sir, the patient reported that.

11 THE COURT: Well, you understand the importance of  
12 making the distinction?

13 THE WITNESS: Yes, Your Honor. I'm sorry.

14 THE COURT: All right.

15 THE WITNESS: He reported the two mining accidents  
16 and apparently suffered further injuries as he reported those  
17 to me.

18 BY MR. WILLIAMS:

19 Q. Okay. Did you conduct independent investigations and do  
20 an examination on Mr. Bowman?

21 A. I did do an examination on Mr. Bowman. It's not common  
22 practice in medicine to conduct independent investigations.

23 Q. I guess what I'm saying with that is would you try to  
24 review any and all charts and the past medical records, MRIs,  
25 X-rays?

1 A. Yes, sir.

2 Q. Okay. All right. Now, with Mr. Bowman, let's back up  
3 here just a little bit with his pain assessment tool.

4 Where the diagnosis codes are filled in, do you know  
5 what those diagnosis codes are?

6 A. It would appear -- I mean, I recognize the 338.21. That  
7 is severe chronic pain due to trauma. And then the different  
8 other codes primarily relate to, again, radiculitis, neuritis,  
9 radiculopathy, nerve pain, shooting pains. I believe these  
10 are the ICD-9 codes from 2015.

11 Q. All right. Based upon your treatment, do you believe  
12 that he had a legitimate medical need for what you prescribed  
13 him?

14 A. Absolutely. Yes, sir. My objective findings certainly  
15 indicated that.

16 Q. We can go to Deborah Brown.

17 Okay. And what about Ms. Brown?

18 A. So I don't believe Ms. Brown was a patient for very long.  
19 It doesn't indicate here that I found her most significant  
20 problems on physical exam to be in her lower back. And  
21 that -- the "LS" is lumbar spine -- and that those -- that  
22 pain and those symptoms related to that pain were greater on  
23 the right side as opposed to the left. That's why, "R greater  
24 than L," right side is greater than the left side.

25 Q. And the numbers that would be up here in the corner --



1 A. Those would be her vital signs; weight of 221 pounds,  
2 blood pressure 180 over 99, heart rate of 81, oxygen  
3 saturation of 97 percent.

4 Q. Now, as we go forward, this would be the Initial Intake  
5 Form; is that correct?

6 A. Correct.

7 Q. Okay. And Ms. Brown reported to you what?

8 A. So it appears Ms. Brown reported that quite some time  
9 ago, I believe that said 74 years. Is that -- or maybe its  
10 seven years ago. Sorry. Seven years ago she suffered an  
11 accident in regards to lifting a basket of wet sand.

12 Q. Okay. And you conducted an examination of her; is that  
13 correct?

14 A. Correct, yes, sir.

15 Q. Okay. And you consulted MRIs, whatever would be  
16 available?

17 A. I consulted all available medical records at the time.

18 Q. Okay. And based upon that, you felt like there was a  
19 legitimate medical need.

20 A. Based on my objective findings from my examination of  
21 her, yes, that she had a legitimate medical need to be treated  
22 for her diagnosis.

23 Q. Okay. If we can move to Clayton Colegrove.

24 You believe Ms. Brown had a continuing medical need,  
25 too, throughout the treatment?

1 A. Yes, sir.

2 Q. Now, on Mr. Colegrove, starting on page -- let's see.  
3 Start with page 47 here. Once again, what are those?

4 A. Those are the diagnoses for Mr. Clayton Colegrove.

5 Q. Okay. And those would be what?

6 A. Severe chronic pain due to trauma, chronic pain syndrome.

7 Q. Okay. And vital signs were taken; is that correct?

8 A. That is correct.

9 Q. With respect to the Initial Intake Form, what was it  
10 Mr. Colegrove presented to you that his injuries were from?

11 A. So Mr. Colegrove reported experiencing a severe accident  
12 with his coal truck and in the course of that severely injured  
13 his low back. And as a result of that injury to his low back,  
14 he reported significant radiating pains into his legs.

15 Q. Okay. What did you do with respect to trying to check  
16 that to confirm those injuries?

17 A. I would have reviewed all available medical records that  
18 I was provided, and he would have undergone a physical  
19 examination.

20 MR. RAMSEYER: Your Honor, again, I'd object to what  
21 he would be doing. I think he can testify to what he did.

22 THE WITNESS: My apologies.

23 BY MR. WILLIAMS:

24 Q. What did you do?

25 A. He underwent a physical examination, as well as a past

1 medical history and a complete review of his records that were  
2 provided. And based on my objective findings, he had a  
3 legitimate medical need to be treated, and I treated him.

4 Q. Okay. Did he have a continuing need?

5 A. Yes, sir.

6 THE COURT: Doctor, when you say "provided," you  
7 mean brought to you by the patient? Is that what you're  
8 saying?

9 THE WITNESS: In some cases they were brought by the  
10 patient. In many cases they were faxed. We would send  
11 medical records requests to their primary care specialist and  
12 those records would be directly faxed to us from their health  
13 care entity. And that's how we preferred to receive those  
14 documents.

15 THE COURT: All right. Thank you.

16 BY MR. WILLIAMS:

17 Q. Now, in the essence of time, all of these forms that  
18 we're showing have further information that you used to assess  
19 this; correct?

20 A. That is correct, yes, sir.

21 Q. Okay. In essence of time, we're trying to go forward  
22 with just showing the main things. Okay.

23 Now, with respect to Ms. Craycraft, what did  
24 Ms. Craycraft represent to you was wrong with her?

25 A. She reported to being ejected from a vehicle when she was

1 traveling and as a result of that suffered a fracture in her  
2 low back that she reported.

3 Q. Okay. What did you notice of Ms. Craycraft? Was there  
4 anything you observed about her?

5 A. She walked with a limp and she had noted restricted range  
6 of motion on physical examination --

7 Q. Okay.

8 A. -- due to -- I mean, she was pinned under a truck when  
9 she was ejected in that car accident -- reported.

10 THE COURT: Again --

11 THE WITNESS: In that reported car accident, she was  
12 reported to have been pinned under a truck and suffered a low  
13 back fracture.

14 BY MR. WILLIAMS:

15 Q. All right. And Ms. Craycraft, this would be her  
16 diagnosis codes?

17 A. Yes, those would be the initial diagnosis codes.

18 Q. And they would be involving what?

19 A. Again, those are the ICD-9 codes. I have not used those  
20 codes in quite some time.

21 Q. She complains, though, with lower back pain; is that  
22 correct?

23 A. Yes. And her objective findings on physical examination  
24 and direct medical history confirmed severe chronic pain due  
25 to trauma.

1 Q. Okay. Do you believe she had a legitimate medical need?

2 A. She had a legitimate ongoing need for treatment.

3 Q. Okay. If we can go to Mr. Damron. What do you we see  
4 initially with Mr. Damron here?

5 A. So in this case I did not use diagnosis codes. I simply  
6 wrote out his diagnosis of chronic cervical pain with spasms  
7 and chronic low back pain with radiculopathy. And again,  
8 radiculopathy, whatever part of the body that occurs in,  
9 whether it's cervical radiculopathy or low back, it's  
10 indicating that there is most likely a pinched nerve root in  
11 that part of the body somewhere and it's -- depending on the  
12 patient and how compressed that nerve root is, it's -- you're  
13 getting the shooting pains from that injury and from that  
14 chronic pain issue.

15 Q. Okay. And looking at the initial assessment form, what  
16 does Mr. Damron claim to be injured by?

17 A. Again, he was -- he reported -- he reported he was in a  
18 coal mining accident where he was in a coal mine collapse is  
19 what he reported.

20 Q. Okay. And did you do any objective testing?

21 A. Yes. He received a physical examination, focused  
22 physical examination on his specific issues. And those  
23 confirmed the diagnosis, which was for a legitimate medical  
24 need.

25 Q. All right. If we can, let's go to -- let's see. We just

1 finished with Mr. Damron.

2 Go to Hassel Daniels.

3 All right. With respect to Mr. Daniels, what did  
4 you see with Mr. Daniels here with his Initial Pain Assessment  
5 Tool?

6 A. He was diagnosed with severe chronic pain due to trauma.  
7 It would appear due to his physical examination his most  
8 significant area of ongoing chronic pain was focused in his  
9 lower back with radiation into -- into his right leg, upper  
10 leg and buttock area. He also had some radiation into his  
11 left buttock area. But the more prominent radiculopathy or  
12 radiation was into his right side.

13 Q. Okay. And with respect to his initial assessment, what  
14 did Mr. Daniels report to you was the cause of his accident?

15 A. So, again, he was a former coal miner. He reported a  
16 severe mine collapse and that this occurred -- that he was  
17 involved in -- he reported he was involved in at least four  
18 mine collapses as a coal miner, and his last one was the  
19 primary cause of his most significant injuries.

20 Q. Okay. And did you conduct objective testing on  
21 Mr. Daniels?

22 A. I did.

23 Q. Okay. And what else did you do with respect to  
24 Mr. Daniels?

25 A. I believe with Mr. Daniels, whatever medical records

1 would have been available would have also been used. I  
2 believe in this case we had additional medical records that  
3 were reviewed and additional medical records may have been  
4 ordered in his case due to the age of his medical records that  
5 he provided.

6 Q. When you mentioned that, what would be some examples of  
7 why you wouldn't automatically do new MRIs or something when a  
8 patient comes in?

9 A. Well, you know, doctors have been diagnosing chronic pain  
10 before the MRI was invented, even before the X-ray was  
11 invented. MRIs have been around --

12 MR. RAMSEYER: Your Honor, I object to what's been  
13 going on for years.

14 THE COURT: Well, yes. Why don't you just explain  
15 why you didn't use MRIs.

16 THE WITNESS: Well, that was very rare. Normally we  
17 did have an MRI on file for the patient, but as respect --  
18 were you asking about how long?

19 BY MR. WILLIAMS:

20 Q. Why would you not do a new one all the time?

21 A. Right. As Dr. Bassam mentioned, they're very expensive  
22 tests. Many of my patients have no insurance. Many of them  
23 had Medicaid, which was just a state program that wouldn't pay  
24 for tests if doctors -- in Kentucky and West Virginia  
25 specifically, they won't pay. So if you order a test, even a

1 lab test, they won't pay for that patient's lab test unless --

2 MR. RAMSEYER: Your Honor, I object. I think he's  
3 just saying stuff.

4 THE COURT: Well, I mean, he -- you're explaining --  
5 I'll overrule the objection, but -- and the jury can consider  
6 that.

7 You're just saying that they're expensive tests.

8 THE WITNESS: Correct.

9 THE COURT: Okay. So that's the bottom line.

10 THE WITNESS: Yes, sir.

11 THE COURT: So any other reason?

12 THE WITNESS: The other reason you wouldn't order a  
13 new MRI right away is if, based on the current MRI, there  
14 hadn't been substantial change in the patient's condition  
15 since their most recent MRI.

16 BY MR. WILLIAMS:

17 Q. And do you believe based on your examination and  
18 everything that you did on Mr. Hassel Daniels that he had a  
19 legitimate medical need?

20 A. Yes, sir.

21 Q. And it continued throughout your treatment?

22 A. It did, yes, sir.

23 Q. And with respect to Mr. Robert Daniels, what did  
24 Mr. Robert Daniels report to you was his injury?

25 A. So, again, this was another long-time coal miner that he



1 reported a couple of severe accidents in the mine. One he  
2 reported from 1999 resulted in a right wrist fracture that  
3 also severely injured his back and neck. In 2010, while  
4 working as a roof bolter in a high coal ridge, my  
5 understanding of that is it's a higher roof or ceiling in the  
6 coal mine, he was compressed in a wall collapse and this  
7 severely injured his lower back. And he reported --

8 THE COURT: That's all what he told you; is that  
9 right?

10 THE WITNESS: Yes, sir. That's all reported.

11 BY MR. WILLIAMS:

12 Q. Okay. Now, you conducted other testing on him as well?

13 A. Yes. We -- he underwent a physical -- a focused physical  
14 examination and a medical record review in determining his  
15 final diagnosis.

16 MR. RAMSEYER: Your Honor, I object. I don't think  
17 the answer was responsive. The question was: You conducted  
18 testing of him?

19 BY MR. WILLIAMS:

20 Q. Okay. Did --

21 THE COURT: Well, I'll overrule the objection. But  
22 you say -- did you conduct other testing on him?

23 THE WITNESS: From a medical standpoint, Your Honor,  
24 physical examination is a form of testing, as I understand it.

25 THE COURT: And you also said medical record review.

1 That's not testing.

2 THE WITNESS: That is not a test, no, Your Honor.

3 THE COURT: Okay. Well, try to answer the questions  
4 directly, please.

5 THE WITNESS: Yes, sir.

6 BY MR. WILLIAMS:

7 Q. And you did a physical exam on that; correct?

8 A. Yes, sir.

9 Q. On Mr. Robert Daniels?

10 A. Yes, sir.

11 Q. Now, looking at the initial pain assessment, do you  
12 recognize any of those codes that you've had?

13 A. Yes. The first one, 338.21, is severe chronic pain due  
14 to trauma. That was his primary diagnosis.

15 Q. Okay. And, based upon your examination and everything  
16 you did, you believe he had a legitimate medical need for the  
17 medications you prescribed?

18 A. Based on my objective findings he had a medical need to  
19 be treated and that was an ongoing need.

20 Q. Donna Dotson. What do you know about Ms. Dotson?

21 A. She was a patient of mine.

22 Q. Okay. Without looking at anything, do you recall  
23 anything much about her while I'm pulling this up?

24 A. She -- I believe -- well, Ms. Dotson was a patient from  
25 Kentucky. She is the mother of Shannon Kovalski.

1 Q. What did Ms. Dotson -- based upon the document here in  
2 front of you, what did Ms. Dotson report to you was her  
3 injury, the cause of her injury?

4 A. She reported -- she reported a diagnosis of rheumatoid  
5 arthritis from the year 2000 and that in 2010 she suffered  
6 from osteomyelitis in her left tibia. Osteomyelitis is an  
7 infection of the bone that can be very painful and sometimes  
8 does not completely heal correctly depending on how it's  
9 treated.

10 In 2010 she reported a major fall in her bathtub and  
11 in 2007 a motor vehicle accident that resulted in severe neck  
12 and head trauma -- neck and back -- severe neck and back  
13 sprain. She also indicated that her pain was gradual but it  
14 had worsened.

15 Q. Okay. Now, is this the Initial Pain Assessment Tool that  
16 you did on Ms. Dotson?

17 A. This would be, yes, sir.

18 Q. Okay. And do you recognize any of the diagnosis codes?

19 A. Yes, sir, I do. She had diagnosis for chronic pain  
20 syndrome. She had an incorporated diagnosis regarding her  
21 rheumatoid arthritis. She also had a diagnosis that I  
22 provided based on physical examination of neuralgia and  
23 radiculopathy.

24 Q. Okay. And based upon your examination of her -- did you  
25 examine her?

1 A. Yes, sir.

2 Q. Okay. Based upon your examination, did you find that she  
3 had a legitimate medical need?

4 A. Yes, sir.

5 Q. And a continuing medical need?

6 A. Yes, sir.

7 Q. Let's go to Stephen Fearin.

8 Okay. Mr. Fearin's Initial Assessment Tool. Do you  
9 recall what that number would be?

10 A. I do not recall off the top of my head. I believe it's  
11 due to low back pain --

12 Q. Okay.

13 A. -- which appears to be his number one most significant  
14 issue on his physical exam that I noted.

15 Q. Okay. On his Physician Intake Form, this would be SF-20,  
16 what did Mr. Fearin report was the cause of his injury?

17 A. Mr. Fearin was a sawyer, and he climbed trees for a  
18 living, and at one point in doing that he reported that he had  
19 a significant fall and that, in one case, a tree actually fell  
20 on him while he was logging.

21 Q. You believed he had a legitimate medical need at the time  
22 that you prescribed it?

23 A. I did.

24 Q. And you believe that he continued throughout the  
25 treatment?

1 A. Yes, I did.

2 Q. Okay. Brenda Fisher, page 29.

3 All right. What do you see with respect to  
4 Ms. Fisher's Initial Intake Form? What did Ms. Fisher report  
5 to you?

6 A. She reported quite a few things. One of the significant  
7 things we discussed here is her diagnosis of cancer with  
8 metastasis that she reported to her ovaries and fallopian  
9 tubes. She had undergone treatment with radiation. That is  
10 what she reported, as well as excisional biopsy.

11 Q. Okay.

12 A. She also suffered from other significant pain issues.

13 Q. Ms. Fisher was in here earlier just two or three  
14 witnesses ago; correct?

15 A. Yes, sir.

16 Q. Now, get to page 37. Here we go. On page 29, is this  
17 Ms. Brenda Fisher's Initial Assessment Tool?

18 A. Yes, it is.

19 Q. And what were the diagnoses on that?

20 A. Severe chronic pain due to trauma.

21 Q. Okay. And did you conduct an independent examination of  
22 Ms. Fisher?

23 A. I did.

24 Q. Okay. And -- did I just ask you if they -- what the  
25 codes were?

1 A. Yes, sir. Severe chronic pain due to trauma.

2 Q. Okay. And based upon Ms. Fisher's -- your examination --  
3 did you examine Ms. Fisher?

4 A. I did.

5 Q. Okay. Based upon that examination and any outside  
6 information that you would have acquired, did you believe she  
7 had a legitimate medical need?

8 A. She did.

9 Q. This is Candy George. What did Ms. George report to you?  
10 It's page 3.

11 A. She indicated a number of -- reported a number of causes  
12 for her ongoing pain from cheerleading and car accidents.  
13 Also to -- she was, at that time as well, a horse caretaker, I  
14 believe.

15 MR. RAMSEYER: Your Honor, again, not clear that's  
16 what she told him.

17 THE WITNESS: That's what the patient indicated.  
18 The patient also indicated she had been thrown from horses  
19 five different times.

20 BY MR. WILLIAMS:

21 Q. Okay. This is the Initial Pain Assessment Tool. Do you  
22 recognize any of those codes up at the top?

23 A. Yes, sir. Again, 338.21 is the ICD-9 code for severe  
24 chronic pain due to trauma, diagnostic code --

25 Q. Okay.

1 A. -- which is a diagnosis I gave her.

2 Q. Okay. And did you conduct an examination on her?

3 A. I did.

4 Q. Okay. And did you try to review any and all records that  
5 were available to you?

6 A. I did.

7 Q. Okay. And based upon that, did you feel like she had a  
8 legitimate medical need at that time?

9 A. Yes, sir.

10 Q. And the medication you prescribed?

11 A. Yes, sir.

12 Q. And did you also feel like it was a continuing need?

13 A. Yes, sir.

14 Q. Okay. Bryan Harlow, page 54. And what did Mr. Harlow  
15 report to you?

16 A. So Mr. Harlow reported significant injury in the coal  
17 mines.

18 Q. And what pain was he suffering from at that time did he  
19 indicate?

20 A. He indicated that as a result of the coal mine injury  
21 that he had severe injury to his right shoulder and his low  
22 back with radiation into his left leg.

23 Q. Okay. And did you conduct an examination of him?

24 A. Yes, sir.

25 Q. And is this the Initial Pain Assessment Tool that you had

1 with respect to Mr. Harlow?

2 A. Yes, sir, it appears so.

3 Q. Okay. Any diagnosis that you see there?

4 A. He had quite a bit of nerve damage and shooting nerve  
5 pain that was further assessed on further exam. ICD-7 --  
6 ICD-9 code 724.4. That would be lower back pain. He  
7 definitely also suffered from severe chronic pain due to  
8 trauma.

9 Q. Okay. Now, I think you did say you did an examination on  
10 him?

11 A. Yes, sir.

12 Q. Okay. And based upon it and the assessments that you  
13 made, did you feel like he had a legitimate medical need?

14 A. Yes, sir.

15 Q. Go to John Harlow. Okay. Mr. Harlow, what did  
16 Mr. Harlow report to you?

17 A. He reported being in an altercation in 2002 in which he  
18 was hit in the head and neck with a slate bar.

19 Q. Okay. And what was he complaining of? His injuries?

20 A. He was complaining of significant ongoing chronic neck  
21 pain and low back pain --

22 Q. Okay.

23 A. -- that it occurred suddenly and were worsening.

24 Q. And did you conduct an examination of him?

25 A. Yes, sir.



1 Q. And did you also do an initial pain assessment?

2 A. Yes, sir.

3 Q. And what was your diagnosis?

4 A. He received multiple diagnoses that most significant of  
5 which would be severe chronic pain due to trauma.

6 Q. Okay. And he was complaining with, what did you say?  
7 His neck and back and left shoulder?

8 A. Correct. It would also indicate here that on my physical  
9 examination his most prominent issue actually was his left  
10 knee and a secondary issue was what he initially complained  
11 of. And this was not uncommon that on physical exam other  
12 issues would come up that the patient was suffering from.

13 Q. And based upon your examination and everything available  
14 to you, did you feel like he had a legitimate medical need for  
15 the medicine prescribed?

16 A. Yes, sir.

17 Q. And did you feel like it was a continuing need?

18 A. Yes, sir.

19 Q. Pam Harlow. Okay. Ms. Harlow, this is her Initial Pain  
20 Assessment Tool; is that correct?

21 A. Yes, sir.

22 Q. Okay. And what does it indicate as far as the diagnosis?

23 A. Based on my physical exam findings, her most prominent  
24 significant chronic issue is her lower back, which is showing  
25 radiating pain greater into her left leg and a diminished

1 amount of radiating pain into her right.

2 Q. Okay. Now, the Initial Pain Assessment Tool, is that  
3 something you did?

4 A. Yes, this is something I documented as I was going  
5 through the exam with the patient. I would perform the  
6 physical examination, then I would immediately sit down and  
7 document it and discuss my findings with the patient as I move  
8 through the visit with them.

9 Q. Okay. Now, on page 75, the New Patient Intake Form, now,  
10 this, differing from the other, is something that the patient  
11 would fill out; correct?

12 A. Correct. This is a document that they would be handed on  
13 a clipboard and they would fill out several pages. Like I  
14 said, I think it was 28 pages that they filled out on their  
15 initial visit to my office.

16 Q. Okay. And this -- Ms. Pam Harlow, what did Ms. Pam  
17 Harlow complain was the cause of her accident?

18 A. She indicated to me that she had an accident with a  
19 wheelbarrow that resulted in four back surgeries and a spinal  
20 cord stimulator that had been placed in 2001, and the  
21 batteries were -- at the time of this report, had run out.

22 Q. According to her; correct?

23 A. According to her, yes.

24 Q. Okay. And based upon your examination and evidence that  
25 you gathered, did you feel like she had a legitimate medical

1 need?

2 A. Yes, sir.

3 Q. Heather Hartshorn. This would be the Initial Intake  
4 Form. This would have been what Heather Hartshorn filled out  
5 again; correct?

6 A. Yes, sir.

7 Q. And what did Ms. Heather Hartshorn fill out was the cause  
8 of her injuries?

9 A. She indicated, or reported, multiple chronic ongoing  
10 issues in her lower back, her legs, her knee, her hips, and  
11 her neck. And the causes for these different pain issues  
12 varied between two prominent accidents she had suffered: One  
13 was a slip, and fall and another was a severe car accident  
14 that she had suffered.

15 Q. Okay. And is this the Initial Pain Assessment Tool that  
16 you prepared?

17 A. Yes, sir.

18 Q. Okay. And what were the diagnoses on those?

19 A. Severe chronic pain due to trauma, chronic pain syndrome,  
20 and I believe a lower back radiculopathy.

21 Q. Okay. And did you do a physical exam on her?

22 A. Yes, sir.

23 Q. Okay. And based upon your physical exam and anything you  
24 observed and looked at, reports, X-rays, things like that, did  
25 you feel like she had a legitimate medical need?

1 A. She had a legitimate ongoing medical need for treatment.

2 Q. And you felt like that continued throughout the  
3 treatment?

4 A. Yes, sir.

5 Q. Bobby Hopkins. This, again, is the Initial Intake Form  
6 regarding Mr. Hopkins. This would be what Mr. Hopkins  
7 reported to you; correct?

8 A. This would be, yes, sir.

9 Q. And what did Mr. Hopkins report was the cause of his  
10 injury?

11 A. Just based on this form, he reported that he had disk  
12 disease of four years' duration, and it would be in his neck.

13 Q. All right. And is this the Initial Pain Assessment Tool  
14 that you would have prepared?

15 A. Yes, sir, this is.

16 Q. Okay. And what were the diagnoses that you came up with  
17 at that time?

18 A. This would be -- within those diagnosis codes listed  
19 would be chronic neck pain or cervical pain, as well as  
20 cervical radiculopathy from likely compression of spinal nerve  
21 roots, as well as low back pain and radiculopathy in the lower  
22 back.

23 Q. All right. And did you conduct a physical exam on  
24 Mr. Bobby Hopkins?

25 A. Yes, sir.

1 Q. And based upon the exam and the -- any MRIs, X-rays or  
2 anything, documents, reports in your physical observations,  
3 did you feel like he had a legitimate medical need?

4 A. Yes, sir.

5 Q. Donald Hopkins. This is the Initial Pain Assessment  
6 Tool?

7 A. Yes, sir.

8 Q. What is the diagnosis that you have there for Mr. Donald  
9 Hopkins?

10 A. Those would be diagnosis codes related to chronic low  
11 back pain and chronic low back radiculopathy or radiating  
12 nerve pain.

13 Q. All right. Now, this is the Initial Intake Form filled  
14 out by Mr. Hopkins, Donald Hopkins. And what does Mr. Hopkins  
15 report as the cause of his injury?

16 A. He reported that he had suffered a car accident in 2008  
17 and that his chronic pain as a result of that motor vehicle  
18 accident was worsening.

19 Q. Okay. And based upon your physical examination and  
20 reviewing the MRIs, X-rays, or whatever would have been  
21 available to you in your physical observation, did you feel  
22 like he had a legitimate medical need?

23 A. He did. He had an ongoing legitimate medical need for  
24 treatment.

25 Q. Go to Samuel Hubbard.

1 THE COURT: All right. Mr. Williams, we've been  
2 going for a while here. We're going to take a break at this  
3 time. Ladies and gentlemen, if you'll follow the bailiff out,  
4 please.

5 (Proceedings held in the absence of the jury.)

6 THE COURT: All right. Anything that we need to  
7 take up?

8 MR. RAMSEYER: Your Honor, one matter. With it  
9 being the defendant, is he allowed to talk to his attorney now  
10 that he's in the middle of his testimony?

11 THE COURT: Yes, sir.

12 MR. RAMSEYER: Okay. Thank you.

13 THE COURT: All right. If there's nothing further,  
14 we will be in recess.

15 (Proceedings suspended at 2:20 p.m. and resumed at 2:36  
16 p.m.)

17 THE COURT: Are we ready to bring the jury in?

18 MR. WILLIAMS: We are.

19 THE COURT: All right. We'll have the jury in.

20 (Proceedings held in the presence of the jury.)

21 THE COURT: All right. You may proceed.

22 MR. WILLIAMS: Thank you, Your Honor.

23 BY MR. WILLIAMS:

24 Q. Dr. Smithers, if you will, let's start with Samuel  
25 Hubbard. Okay.

1           Showing what is his Initial Pain Assessment Tool.

2       Once again, that is the tool that you provided; correct? Or  
3       that you did your findings on?

4       A.    Yes, sir, that is correct. Everything on there is filled  
5       out by me.

6       Q.    All right. What is the diagnosis on that?

7       A.    He had a number of diagnoses. Mr. Bo Hubbard, Sr., he  
8       suffered from severe chronic pain due to trauma, but he had a  
9       number of different chronic pain and chronic pain-related  
10      diagnoses that required treatment.

11      Q.    Okay. And what is he primarily complaining with?

12      A.    So his -- from my physical examination there, his most  
13      prominent complaint would be in his lower back. And he had  
14      associated radiculopathy with that chronic lower back pain  
15      with shooting pains into his lower extremities. In this case  
16      it would be worse on the left lower extremity than on the  
17      right lower extremity.

18      Q.    Okay. And you had a diagnosis of severe chronic pain; is  
19      that correct?

20      A.    Yes, sir.

21      Q.    Okay. And based upon the -- Mr. Hubbard's -- what was  
22      his report of what was wrong with him?

23      A.    Mr. Hubbard, he indicated that he had suffered a  
24      traumatic fall -- and this is while he was a water utility  
25      worker -- from about 60 to 70 feet. And his report to me was

1 that most of his ongoing chronic pain issues were a result of  
2 that. He had also, at one point, had his left leg he reported  
3 given out. He fell down 13 to 14 concrete steps and that  
4 pretty much finished off his neck is what he reported. That  
5 caused severe injury to his neck.

6 Q. Okay. We'll go to Blakely Hurley (sic) this is Initial  
7 Pain Assessment Tool on Blakely Hurley; is that correct?

8 A. Yes, sir.

9 Q. Okay. What is your findings on Mr. Blakely Hurley?

10 A. Mr. Hurley, he also had a diagnosis of severe chronic  
11 pain due to trauma. In addition to that, he had a  
12 diagnosis -- the M54.10, that would be radiculopathy, the  
13 nerve pain, spinal root nerve disease.

14 Q. Okay. And with Mr. Hurley, this is his Initial Pain  
15 Assessment; is that correct?

16 A. Yes, sir.

17 Q. Okay. What did Mr. Hurley report was his injuries?

18 A. He reported a couple of significant injuries: One, while  
19 working in the coal mines he suffered a severe lower back  
20 injury that he reported from 2001. And that also in 2001 is  
21 when he first injured his neck, according to him, and this was  
22 a severe injury as a result of running into a roof bolt --

23 Q. All right. Did you conduct a physical exam on him?

24 A. -- which cracked his safety helmet and caused severe neck  
25 injury.



1 Yes, sir.

2 Q. Now, Ms. Deanna Jessie. Okay. This is her Initial  
3 Intake Form?

4 A. Yes, sir.

5 Q. What is Ms. Jessie reporting is her injury?

6 A. She indicated a history of having slipped and fallen in  
7 Walmart and also a motor vehicle accident that left her with  
8 ongoing chronic lower back pain.

9 Q. Okay. And your findings, these would be your findings on  
10 that day; is that correct?

11 A. Yes. I listed severe chronic pain due to trauma. She  
12 also suffered from chronic back pain, low back pain, as well  
13 an associated radiculopathy, among other diagnoses that I've  
14 determined.

15 Q. Okay. If we go to Rebecca Jessie. Okay. What is  
16 Ms. Rebecca Jessie's -- what's your initial diagnosis?

17 A. So my initial diagnosis I wrote -- CLBP is chronic low  
18 back pain with lumbar radiculopathy which is --

19 Q. What's radiculopathy?

20 A. That's where -- radiculopathy can be caused by a  
21 structural damage to the spinal nerve root.

22 THE COURT: The question was what is it, not where  
23 does it come from. What is it?

24 THE WITNESS: That is it, Your Honor.

25 THE COURT: I mean, is it like skin disease? Is

1 it -- what is it?

2 THE WITNESS: It's a compression or disease of the  
3 spinal nerve root causing shooting pains into the extremities  
4 from the spine.

5 THE COURT: Go ahead.

6 BY MR. WILLIAMS:

7 Q. And so that would have been your finding based upon your  
8 examination?

9 A. Yes, that is correct.

10 Q. Okay. And what was Ms. Jessie reporting?

11 A. She had reported some type of accident. I believe --  
12 well, I believe she reported that that was in a motor vehicle  
13 accident.

14 Q. Okay. And she was complaining of what?

15 A. Significant pain in her lower back. Ms. Jessie, when she  
16 walked -- the entire time she was my patient, I never saw her  
17 standing upright. She typically walked with her body -- with  
18 her entire upper body at an angle at the waist. In some cases  
19 she was almost parallel to the ground. This is due,  
20 typically, to when people have back injuries where if they  
21 straighten up all the way, the back has been injured in such a  
22 way if the bones in the back come together, they actually  
23 compress the nerves. So that's why you see some people just  
24 walk with a forward lean or hunch. Because if they straighten  
25 up, it actually hurts more. It looks really uncomfortable.

1 That's actually a more comfortable position for them.

2 Q. With respect to Rick Jessie, this is his intake form.

3 What was Mr. Rick Jessie reporting?

4 A. He reported multiple car accidents. One of those  
5 involved a semi truck and a rollover that resulted in a severe  
6 sprain of his neck and back is what he reported, also with a  
7 concussion. And typically when a concussion is reported along  
8 with a car accident, that involves injuries to the neck and  
9 back. That -- just like in a football game, that added detail  
10 typically indicates that there was significant trauma to the  
11 areas around the head such as the neck and upper back.

12 Q. Okay. And you did a physical exam on Mr. Jessie?

13 A. Yes, sir.

14 Q. Is this the Initial Pain Assessment Tool?

15 A. Yes, it is.

16 Q. Okay. What was your diagnosis?

17 A. He received several diagnoses chief of which would be  
18 severe chronic pain. He also had different -- different types  
19 of radiculopathy and chronic low back pain. Again, these are  
20 the ICD-9 codes that I'm not as familiar with from years that  
21 have passed since then.

22 Q. Okay. We'll go to Neil Jewell.

23 Okay. Mr. Jewell's intake form. What was  
24 Mr. Jewell reporting was wrong with him?

25 A. He reported that five years prior to our meeting in my

1 office that he had fallen off an explosive -- possibly an  
2 explosive platform. I'm not really sure I can read his  
3 handwriting clearly there.

4 Q. Okay. And what does it say he was complaining with?

5 A. He indicated that as a result of that accident he had  
6 significant ongoing chronic pain to his entire spine from his  
7 neck to his lower back.

8 Q. Okay. This is your Initial Pain Assessment Tool; is that  
9 correct?

10 A. Yes, sir.

11 Q. What was the diagnosis that you had for Jewell?

12 A. He suffered from severe chronic pain due to trauma and  
13 most significant of which was to his lower back, which also  
14 had significant radiculopathy into the lower extremities.

15 Q. You conducted a physical exam on him; is that correct?

16 A. Yes, sir.

17 Q. All right. Let's go to Lora Kicklighter.

18 Okay. What was Ms. Kicklighter reporting?

19 A. She reported a significant motor vehicle accident and  
20 also an ATV accident as the initial cause for her significant  
21 chronic pain.

22 Q. Okay. And she checked that it had worsened over time; is  
23 that correct?

24 A. That is correct.

25 Q. And this is your Initial Pain Assessment Tool on

1 Ms. Kicklighter?

2 A. This is.

3 Q. Okay. And what does it say?

4 A. She was diagnosed with severe chronic pain due to trauma,  
5 and most of that was as a result of the chronic pain found on  
6 physical examination in her lower back that -- with radiation  
7 of that pain into her left and right lower extremities.

8 Q. Okay. Now, was Ms. Kicklighter removed from your  
9 practice?

10 A. She was discharged, yes, sir.

11 Q. Okay. And what was that for? Do you recall?

12 A. I do not recall the specific reason. I would not want to  
13 speculate. It should be in the record.

14 Q. Would it be possible that she tested positive for  
15 cocaine?

16 A. That is possible.

17 Q. Okay. And Shannon Kovaleski, is this her Initial Pain  
18 Assessment Tool?

19 A. Yes, sir.

20 Q. What did you find on Ms. Kovaleski?

21 A. On her physical examination she actually had some really  
22 significant what I believed to be post-surgical muscle  
23 imbalance in her midback due to the surgery she had had for  
24 breast reduction and the -- her body habits. The way she  
25 carried her posture, she developed significant muscle spasms

1 that were relatively equal in the middle of her back and this  
2 resulted in severe chronic pain.

3 Q. Okay. And what did Ms. Kovaleski report on her initial  
4 report?

5 A. She indicated that she had had a significant weight gain  
6 in 2008 and that that's when her pain began. She also  
7 indicated a history of being a gymnast from the fifth grade to  
8 her freshman year of college at Marshall State. And she was  
9 also diagnosed with macromastia, which is enlarged breasts, in  
10 2009 by Dr. Haaser and she had bilateral reduction or  
11 mammoplasty.

12 Q. Okay. Did you do a physical exam on Ms. Kovaleski?

13 A. Yes, sir.

14 Q. Were you aware of any relationship between her and  
15 Mr. Bodai in your office?

16 A. At no time.

17 Q. Okay. Billie Lindsay. This is Ms. Lindsey's intake  
18 report. What does Ms. Lindsay report?

19 A. She indicated -- she indicated she had degenerative disk  
20 disease. When I further interviewed her --

21 It may help if you scroll up a little bit.

22 Q. Oh, sorry.

23 A. She -- I don't see that she's indicating a cause in this  
24 case, but she is indicating the areas where she had -- has  
25 significant debility and pain.

1 Q. Okay. This is your initial pain assessment?

2 A. Correct.

3 Q. Okay. And what was your finding on this?

4 A. Based on the physical exam notes that I put here, there  
5 was significant pain in the upper back and neck, as well as in  
6 the lower back with bilateral radiculopathy into the upper  
7 buttocks.

8 Q. Okay. Let's go to James Long.

9 Did you conduct a physical exam on her?

10 A. On Ms. Lindsay?

11 Q. Yes.

12 A. Yes, sir.

13 Q. James Long. This is his Initial Pain Assessment Tool?

14 A. Yes, sir.

15 Q. Okay. And what is your diagnosis on Mr. Long?

16 A. Based on documentation available, his chief diagnosis was  
17 pancreatitis --

18 Q. Okay.

19 A. -- which was his primary chronic pain issue that he  
20 suffered from. He also had a secondary chronic pain issue  
21 with lower back pain.

22 Q. Okay. And what did Mr. Long report?

23 A. He reported that in 2007 his pain began due to a fall,  
24 and it began suddenly and it was worsening or had worsened.

25 Q. Okay. Joshua Marian. Okay. This is the Patient Intake

1 Form. What was Mr. Marian reporting that his injuries were?

2 A. I'm not sure that I can read all of his handwriting. He  
3 is indicating that he suffered from low back pain as well as  
4 pain in his legs and feet.

5 Q. Also in his hip; is that correct?

6 A. Correct. Also in his hip and looks like also in his neck  
7 as well.

8 Q. Okay. His initial pain assessment, what did you find?

9 A. It appears on this physical examination his most  
10 prominent cause for chronic pain is his low back pain, which  
11 is the diagnosis code listed there, I believe. He also --  
12 apparently, I document there that he suffered from  
13 Calve-Perthes disease, which is a degenerative condition that  
14 can result in severe chronic pain.

15 Q. Jerry Maynard. Mr. Maynard, was this your Initial  
16 Assessment Tool?

17 A. Yes, sir. This is for Mr. Jerry Maynard.

18 Q. Okay. And what was his diagnosis?

19 A. His diagnosis was chronic low back pain, and he had  
20 greater radiculopathy on the left side as compared to the  
21 right.

22 Q. Okay. In his Initial Assessment Tool, what was he  
23 reporting as his injury?

24 A. He reported multiple ATV accidents and falling off of a  
25 horse.



1 Q. Resulting in back, leg, neck, and arm pain?

2 A. Correct, resulting in multiple different chronic pain  
3 complaints.

4 Q. Amanda Miles. What's Ms. Miles initially reporting as  
5 her cause of pain?

6 A. She had multiple car wrecks.

7 Q. Okay. And what's she -- her chief complaint?

8 A. Upper middle back pain, joint pain across her back, down  
9 her back into the legs, through the arms and neck, joint pain,  
10 hips and elbow, numbing and tingling pain.

11 Q. Okay. Did you do a physical exam on her?

12 A. Yes, sir.

13 Q. And based upon your physical exam and anything you took  
14 into account, what was your assessment with respect to pain?

15 A. Based on my objective finding, she was diagnosed as --  
16 accordingly, and treated for the general medical need.

17 Q. Okay. Charlene Miller. Your Initial Pain Assessment  
18 Tool was what with Ms. Miller?

19 A. Her most significant problem -- this was at the time she  
20 was still undergoing post-cancer treatment surveillance, and  
21 her most significant problem was her low back pain, which  
22 corresponded with some of the cancer treatment she had  
23 received. And she had multiple complaints due to multiple  
24 issues in relationship to the chronic pain issues she dealt  
25 with.

1 Q. Oh, I'm sorry. And her Initial Intake Form, what does  
2 she complain with, or what does she indicate to you was her  
3 pain?

4 A. She mentions her lower back with her right leg being the  
5 most prominent. And this is after two back surgeries to her  
6 lower back after working in a factory.

7 Q. Okay. You did a physical exam on her; is that correct?

8 A. Yes, sir.

9 Q. Connie Miller. Ms. Connie Miller, this is her Initial  
10 Pain Assessment Form. What is she complaining with?

11 A. She indicates that her chronic pain is due to a reported  
12 history of lifting too much and a couple of car accidents in  
13 '99 and 2001. And she indicates chronic pain due to domestic  
14 abuse from a past boyfriend.

15 Q. Okay. And your initial pain assessment form?

16 A. So for Ms. Miller, her most prominent chronic pain  
17 diagnosis was in her middle back, and this had radiating pains  
18 that associated with her second most prominent diagnosis,  
19 which was chronic lower back pain, which also had radiating  
20 pain into her right lower extremity.

21 Q. Okay. Jennifer Moore. Her initial pain assessment.

22 A. So she indicated prior to this visit that she had had a  
23 car accident in 2005. It was significant with a rollover in a  
24 collision with a tractor trailer, 18 wheeler. In the process  
25 of the rollover, she indicates that the shift lever collided

1 with her lower back causing a large hematoma from her midback  
2 to her hip on the left side.

3 Q. And your initial pain assessment?

4 A. Yes. And her lower back is where she suffered most of  
5 her chronic pain from, and it was positive on testing with  
6 physical examination.

7 Q. Sharon Mullins. Her Initial Intake Form, she reported  
8 what to you?

9 A. She indicated that she'd been treated for chronic pain  
10 resulting from a car accident, that the pain had gradually  
11 worsened and she'd been receiving treatment off and on since  
12 2001.

13 Q. Okay. And your Initial Pain Assessment Tool?

14 A. On initial examination her lower back was where she  
15 experienced the most prominent ongoing pain with radiculopathy  
16 into the right lower extremity that was more significant than  
17 the left lower extremity, and she also suffered from chronic  
18 neck pain that radiated into her right shoulder.

19 Q. All right. Billy Jack Parsley. Mr. Parsley reported  
20 what to you?

21 A. He indicated that he had had a severe motor vehicle  
22 accident in 2008. And if we can scroll up just a little bit.  
23 He had numerous different injuries that he had sustained and  
24 that he reported. One of his most significant injuries was to  
25 his left knee that he had sustained in high school football

1 and that had caused some recurring chronic pain that he  
2 reported regularly and that we tried to get an orthopedist to  
3 evaluate to see if there was a repair option possible.

4 Q. Now, this is your Initial Pain Assessment Tool; is that  
5 correct?

6 A. Yes, sir.

7 Q. Okay. What was your diagnosis of pain?

8 A. His chief diagnosis was chronic low back pain. And, in  
9 addition to that, he was experiencing more shooting nerve  
10 pain; radiculopathy into the left lower extremity as opposed  
11 to the right. He was also experiencing the left ankle or  
12 joint pain, as well as left knee pain that was significant.

13 Q. Jessica Parsley, her initial pain assessment?

14 A. Her initial pain assessment, she was diagnosed with  
15 chronic pain due to trauma with most of her pain in her lower  
16 back, more to her left side as opposed to her right. She did  
17 have some significant pain at the time in her left knee. And  
18 she kind of had multiple compartment on physical examination  
19 with the front of the knee being marked 1A and the back of the  
20 knee being marked 1B. I was able to elicit pain. That would  
21 indicate that I was able to elicit pain in both compartments  
22 of her knee --

23 Q. Okay.

24 A. -- on physical exam.

25 Q. And Ms. Parsley reported what to you?

1 A. She reported a significant motor vehicle accident that  
2 caused severe injury to her left knee, her lower back, and her  
3 neck, and these gradually became worse.

4 Q. Michelle Smith. Michelle Smith reported what? Or what  
5 was your initial pain assessment for Michelle Smith?

6 A. My initial diagnosis of Ms. Smith was, again, chronic  
7 pain due to trauma along with a constellation of other  
8 diagnoses due to my objective findings and physical  
9 examination. She had significant lower back pain that she  
10 suffered from, and it radiated into her left lower extremity  
11 and also up into her thoracic or midback area.

12 Q. Okay. And Ms. Smith reported what to you?

13 A. She had a significant car accident that she reported in  
14 April of 2015. It caused a fracture to her left forearm, and  
15 this also severely -- she reported this also severely sprained  
16 her mid to low back and left hip with pain radiating into the  
17 left thigh.

18 Q. All right. Nancy Turner, initial pain assessment.

19 A. Ms. Turner also -- she had a diagnosis as chronic pain  
20 due to trauma as well as the lower back -- or I'm sorry --  
21 neck and radiculopathy associated with that. She had  
22 significant -- on physical examination, significant tenderness  
23 and limited range of motion in regards to her upper neck there  
24 and the nerve pain she suffered from.

25 Q. Okay.

1 A. And those diagnosis codes correspond with that.

2 Q. And what did Ms. Turner report to you on her Initial  
3 Intake Report?

4 A. She reported a significant history of a variety of  
5 ailments, all of which have chronic pain as a component.  
6 Typically, fibromyalgia, rheumatoid arthritis, as well as  
7 traumatic causes for her chronic pain such as a motor vehicle  
8 accident that occurred in 1992. And she reported a severely  
9 sprained neck and right leg and low back that were severely  
10 injured as well. She reported a traumatic fall down an HVAC  
11 or ventilation duct chute that severely injured her lower back  
12 in the early 2000s. And she was diagnosed with fibromyalgia  
13 between 2010 and 2012.

14 Q. And we've already done the diagnosis codes, have we not?  
15 Ms. Turner -- we've already done the diagnosis codes on  
16 Ms. Turner; is that correct?

17 A. I believe so, yes, sir.

18 Q. Okay.

19 A. We had --

20 Q. Thomas Wiley. Wait a minute. I skipped one here.

21 Andre White. Initial Pain Assessment Tool?

22 A. Yes. This -- on his physical examination here he  
23 suffered from severe lower back pain with radiating pain into  
24 his left lower extremity, and his chief diagnosis, 338.21,  
25 would be severe chronic pain due to trauma. He also had

1 chronic lower back pain and neck pain, which I believe the  
2 other page will show he reported significant head and neck  
3 injury due to trauma.

4 Q. There's Mr. White's initial pain assessment. What did he  
5 report to you?

6 A. Broken back with scoliosis from 1994.

7 Q. All right. And now Mr. Thomas Wiley.

8 Mr. Wiley's Initial Pain Assessment Tool?

9 A. Yes, sir. He was -- he was also diagnosed with severe  
10 chronic pain due to trauma, in addition to chronic low back  
11 pain. His radiculopathy path was significant in the left  
12 lower extremity more so than the right.

13 Q. Okay. And Mr. Wiley reported what?

14 A. So his report indicated while he was working that he was  
15 lifting and throwing metal rails and that that is how he  
16 initially injured his lower back.

17 Q. Okay. Darryl Williams. What's your initial pain  
18 assessment with respect to Mr. Williams?

19 A. His physical exam indicated that his most severe chronic  
20 pain was in his lower back with radiculopathy greater on the  
21 left side going down into his foot, on the right side stopping  
22 at the back of the knee. Also suffered from knee pain.

23 Q. And what was Mr. Williams reporting?

24 A. Mr. Williams was a very -- he's a very tall man, and he  
25 indicated that he had slipped on ice and fallen down and that

1 he had also, while working in the coal mines, had a coal mine  
2 collapse with rock landing on him. The slip and fall incident  
3 he indicated, along with falling down 14 steps here,  
4 significantly increased his chronic pain.

5 Q. Okay. Now, Frank Williams. What was your initial pain  
6 assessment with respect to Frank?

7 A. So with Franklin Williams -- he went by Scotty Williams.  
8 He also had significant chronic pain due to trauma, among  
9 other significant diagnoses, due to musculoskeletal pain that  
10 he had suffered from his lower back to his left knee to his  
11 neck.

12 Q. Okay.

13 A. And he experienced a significant radiculopathy in his  
14 neck into his left shoulder and upper arm.

15 Q. Okay. And what did Mr. Frank -- or Scotty Williams  
16 report?

17 A. He indicated that he had been crushed in the coal mines  
18 and that a car had fallen on him as the two most significant  
19 accidents he had suffered to cause his significant chronic  
20 pain.

21 Q. Okay. And Wesley Williams.

22 A. So Mr. -- this is Wesley. It says Evans.

23 Q. Let me go -- I'll have to check that one.

24 Let's go to David Wood.

25 A. Okay.



1 Q. Okay. What's Mr. Wood's Initial Pain Assessment Tool?

2 A. So, Mr. Wood, on physical examination, he had significant  
3 pain in his right forearm followed by significant pain in his  
4 neck with radiation of that pain greater into the right  
5 extremity versus the left. And he also suffered --

6 Q. Okay. And your diagnosis was what now? What was your  
7 pain assessment?

8 A. That was the physical examination, which is done after  
9 the medical history, past medical history. So that would have  
10 been formed with physical examination and resulted in those  
11 findings.

12 Q. Okay. And Mr. Wood reported what to you?

13 A. So he indicated about seven years prior to having a motor  
14 vehicle accident and a torn rotator cuff.

15 Q. Okay. And Larry Workman, in his Initial Pain Assessment  
16 Tool, what was the diagnosis?

17 A. Severe chronic pain due to trauma, chronic pain syndrome,  
18 and a lower back radiculopathy.

19 Q. Okay.

20 A. Which, apparently, was completely unilateral. It was  
21 one-sided to the right.

22 Q. Okay. And what was -- did Mr. Workman report to you?

23 A. Mr. Workman indicated he had suffered from a fall. And,  
24 as a result of that fall, he had suffered significant injury  
25 to his lower back. This was a fall off of his porch outside

1 of his trailer. And when he fell down, he injured his lower  
2 back and his right knee.

3 Q. Okay. And you believed all of these prescriptions and  
4 all of your examinations and everything were written with --  
5 for a legitimate medical need?

6 A. Yes, sir.

7 Q. Okay. And you believe that their ongoing treatment was  
8 prudent for a legitimate medical purpose?

9 A. Yes, sir. Until that was established otherwise, that was  
10 my -- as long as I treated them as a patient, that was my  
11 understanding. I was prescribing medication for a legitimate  
12 medical need.

13 Q. Okay. And were -- during the time that you were -- all  
14 of these people that you saw, did you conduct physical exams  
15 on all of them?

16 A. Yes, sir.

17 Q. Okay. And what would you do -- how would you do the  
18 physical exam? I mean, what would you do in physical exam?  
19 Explain to the jury.

20 A. Right. So, as I was saying, I would sit down with them  
21 and go over this form first. So that would inform what I  
22 would do on physical exam. If a patient was not -- I mean, if  
23 they weren't complaining of a problem, that was not further  
24 investigated on physical examination unless there was a clear  
25 medical reason in my mind to do so.

1           The goal in spending a lot of time talking to the  
2 patient was to find out what their actual underlying problems  
3 were so that when I did the physical examination I could focus  
4 on those areas that were most likely the root cause of the  
5 problem that they were having.

6 Q.    Okay. Now, were there significant numbers of patients  
7 you discharged?

8 A.    Yes.

9 Q.    How many patients did you discharge?

10 A.    I don't know the exact number. Most of the charts we've  
11 reviewed so far, I believe, are patients that were discharged.

12 Q.    Is Darryl Williams one that was discharged?

13 A.    Yes, sir.

14 Q.    Is Billy Jack Parsley one that was discharged?

15 A.    No. He overdosed.

16 Q.    Okay. Was Connie Miller discharged?

17 A.    Yes, sir, I believe so.

18 Q.    Was Charlene Miller?

19 A.    I believe so, yes, sir.

20 Q.    Okay. Lora Kicklighter?

21 A.    Yes, sir.

22 Q.    Samuel Hubbard?

23 A.    Yes, sir.

24 Q.    Pam Harlow?

25 A.    I believe so, yes, sir.

1 Q. Bryan Harlow?

2 A. I believe so, yes, sir.

3 Q. Clayton Colegrove?

4 A. I believe so.

5 Q. Jason Bowman?

6 A. Yes, sir.

7 Q. Frank Blair?

8 A. Yes, sir.

9 Q. Mr. Battaglia?

10 A. Yes, sir.

11 Q. And others?

12 A. Yes, several others.

13 Q. Okay. Now, let's talk about -- the Government's talked  
14 about several different things with respect to your practice.  
15 With respect to -- did you take insurance?

16 A. I did not take insurance. I investigated it, and I  
17 started my medical practice without a loan or without any  
18 financial assistance from anyone. And it was going to be very  
19 expensive to take insurance, and I didn't have the funds at  
20 the time to invest in that system. And when you take  
21 insurance, you don't get paid right away from the insurance  
22 company. You typically don't get paid for an office visit for  
23 three, four, six months, sometimes longer. So it was an issue  
24 of being able to pay the bills.

25 The rent for the building I was in alone in

1 Martinsville was \$3,700 a month, I believe.

2 Q. Okay. So were there processes for the patients to be  
3 able to get reimbursed through insurance?

4 A. There were. That was the nature and purpose of the super  
5 bill was so that in many patients who did have insurance --  
6 one patient who had Blue Cross Blue Shield and worked at  
7 General Dynamics here in Virginia, he was reimbursed, I  
8 believe, \$280 a month by Blue Cross Blue Shield. So most of  
9 his office visit was reimbursed because of that super bill.

10 MR. RAMSEYER: Your Honor, I object, unless he has  
11 personal knowledge of that.

12 THE COURT: Yes. How did you know that?

13 THE WITNESS: The patient reported it to me  
14 repeatedly. I can give -- the patient's name is Larry Wayne  
15 Carter.

16 THE COURT: All right. Go ahead.

17 MR. RAMSEYER: Your Honor, I object. I don't think  
18 that's admissible what a patient told him.

19 THE COURT: Yeah. I believe that's not admissible  
20 hearsay. And I'm going to direct the jury not to consider the  
21 statement of the witness as to reimbursement by Blue Cross  
22 Blue Shield of Larry Wayne Carter's charges from the doctor.

23 BY MR. WILLIAMS:

24 Q. Okay. Dr. Smithers, regarding your policies for  
25 discharge, when someone would have a dirty drug screen or

1 something or another, describe -- did you have a policy on  
2 that?

3 A. So I had a policy that -- it was -- I think the easiest  
4 way to describe it was a three-strikes policy. And we had a  
5 three-tiered risk stratification. So we had, at the initial  
6 visit, based on Mr. Wilson's visit with the patient, my visit  
7 with the patient, and their initial urine drug screen in the  
8 office, we -- and the documentation that we had based on those  
9 patient interviews, we would put them into a risk category.  
10 So they would either be a low-risk patient, a moderate-risk  
11 patient, or a high-risk patient. And then, based on that  
12 designation in their file, that informed our policy as far as  
13 how often they were drug screened.

14 So if they were low risk, they were drug screened  
15 once every four to six months. If they were moderate risk,  
16 they were drug tested at least every three months, if not more  
17 often. And then if they were high risk, they were drug tested  
18 every month.

19 Q. Is there a standard policy anywhere that tells you what  
20 you're supposed to discharge a person for?

21 A. There is not, to my knowledge, no, sir.

22 Q. Okay. So it would be an individual doctor's choice?

23 MR. RAMSEYER: Your Honor, I object to that  
24 question. It's leading, for one thing.

25 THE COURT: Well, I'll sustain it. And there's no

1 foundation for the witness's answer. So please disregard that  
2 question, ladies and gentlemen.

3 BY MR. WILLIAMS:

4 Q. Now, describe your relationship with Darryl Williams.

5 A. Darryl Williams was someone that I trusted. I -- he was  
6 one of my initial patients when I was in West Virginia. And  
7 based on my initial evaluation and examination of him, I had,  
8 at that time -- I trusted him. And he -- he was someone that  
9 I -- I felt was trying to help other people. It was -- in  
10 addition to, at that time, just being my only staff.  
11 Occasionally my wife was able to come up and help, but he was  
12 someone that seemed like he cared about other people, and he  
13 seemed like he was concerned about the welfare of other people  
14 that were also in his community that were suffering as a  
15 result of people losing access to their physicians who were  
16 treating their medical issues. And I believed his intentions  
17 were that, that they were good intentions to try and help  
18 people in his community have better access to chronic pain  
19 management and healthcare.

20 Q. Now, you've seen the text messages?

21 A. I have.

22 Q. Okay. Describe to the jury what -- what you thought.  
23 What was your impression of what was going on?

24 A. When they were read here in the courtroom or when it  
25 happened?

1 Q. When it happened.

2 A. Well, at the time it happened, I -- again, this was  
3 someone that I trusted, had the best of intentions at their  
4 heart for these people in their community. And at the time I  
5 made some very unwise decisions to trust someone who was also  
6 a patient at the time to help in a way that is, you know,  
7 certainly -- you know, was not standard practice. But it was  
8 something that I -- you know, I trusted this person. I didn't  
9 have a lot of staff at the time, and I extended trust to this  
10 person to help with certain things. I'm embarrassed and  
11 ashamed, in hindsight, that I did.

12 Q. Were you aware of anything that was going on with him and  
13 the others?

14 A. I was not.

15 Q. Okay. What was your understanding of what Mr. Williams's  
16 role was?

17 A. My understanding was what I just stated, that he was a  
18 concerned member of his community where he lived in Kentucky.  
19 And I knew, based on other patients I treated from that part  
20 of the country, that the access to chronic pain management was  
21 fairly dire. It was very difficult with six months to one  
22 year wait lists being reported.

23 And, you know, I -- he really came across as  
24 somebody who had the other person's best interests at heart.  
25 And I -- I'm a pretty trusting person, and I like to see the



1 best in people, and that's what I saw initially.

2 Q. Okay. Now, with respect to Deborah Reynolds, tell the  
3 members of the jury what happened with Deborah Reynolds.

4 A. So in the context of my relationship at that time with  
5 Mr. Williams, he was not discharged as a patient at that time.  
6 The system that his urine drug screen was on was not available  
7 to me, so I was not aware that he'd already tested positive  
8 for cocaine at that time. When I became aware of that, he was  
9 immediately discharged. But at the time I was not aware he  
10 had tested -- had a positive test.

11 And he presented Ms. Reynolds to me as someone who  
12 was in significant need of a doctor, that she was in an  
13 emergent situation, that she had been in a severe car accident  
14 a few years prior and had multiple pieces of hardware in her  
15 back and had had back surgery and that she ran the largest RV  
16 dealership in Kentucky. He presented her as an upstanding  
17 person in the community.

18 That was, again, in a situation where they had just  
19 suddenly lost their access to a provider, and I had just  
20 recently dealt with a lot of patients in West Virginia and now  
21 at this office that, you know, had lost access to care. And  
22 it's devastating to see these patients that haven't had their  
23 medication or --

24 MR. RAMSEYER: Your Honor, I object. I think the  
25 question was how he got involved with Deborah Reynolds.

1 THE COURT: Yes, sir. What -- you need to answer  
2 the question about Deborah Reynolds.

3 THE WITNESS: Yes, sir.

4 So believing those things, I -- Mr. Williams was --  
5 he was at the office that day, and he had relayed this  
6 information to me previously and was continuing -- I think it  
7 was at the end of the day and I had finished seeing all the  
8 patients that day, and he was continuing to tell me about her  
9 situation. And I asked for her phone number, and I made a  
10 phone call.

11 My recollection of that experience is that I was on  
12 the phone with her between 30 and 40 minutes and that I went  
13 through her complete medical history, as well as her  
14 medication history at the time. It was a phone call, so I  
15 really had no visual way to identify her in that situation.  
16 But that phone number that I had is the same phone number that  
17 she still has today.

18 So my understanding was that I was talking to that  
19 person and that was the situation and that they were in an  
20 emergent situation of needing access to care and that they  
21 would be coming into my office either later that week or the  
22 following week. And that -- and I -- it's the only time in my  
23 entire medical career that I have ever prescribed C-II  
24 narcotics for someone without seeing them face-to-face for an  
25 initial visit, and I regret the decision to this day.

1           And it was -- it was a very bad decision, very poor  
2 judgment on my part to prescribe her medication without seeing  
3 her in the office.

4 BY MR. WILLIAMS:

5 Q.   Now, with respect to -- also with Mr. Williams, what was  
6 your understanding of the payment relationship -- arrangements  
7 with people that he was bringing to the office?

8 A.   So, again, this was a period of time when I didn't have  
9 consistent help managing payments. I mean, I would get  
10 people -- I operated mainly on a paper basis in the office.  
11 We had the three copy receipt books from Walmart. And that's  
12 basically the system I used to keep track of who paid what.  
13 And I was often seeing patients at the beginning of my  
14 practice and not charging the full amount.

15           And, I believe in Mr. Williams's case, there were  
16 many circumstances where I would see several patients, three,  
17 four, five patients, and, you know, nobody had the ability to  
18 pay then, or one person would be able to pay and then the  
19 other people couldn't. And some of these people were on  
20 either fixed income or they weren't -- you know, their  
21 paycheck didn't fall in such a time they could pay the day  
22 they came to the office. So I would treat them and see them  
23 in the office and then whenever we could settle up -- I mean,  
24 sometimes the patient would settle with me directly.

25           Mr. Williams, I think he just kind of became for

1 that -- for a certain group of people, he became the person  
2 that was paying. I mean, again, you know, to look back on  
3 this now, it's -- it was a very naive, very dumb decision to  
4 make. Again, I thought this person had those people's best  
5 interests at heart.

6 Q. Okay? Now, we've heard stuff about FedExing  
7 prescriptions and stuff.

8 A. Yes, sir.

9 Q. Tell the jury about FedExing prescriptions. Did you do  
10 that?

11 A. I did. That was something that I'd only seen done a few  
12 times before. And it was in regards to, you know, people who  
13 are on these medicines long term. As we discussed with the  
14 opiates earlier, once your body --

15 MR. RAMSEYER: Your Honor, object, again. The  
16 question was about the FedExing.

17 THE COURT: Well, I think the witness is explaining  
18 his ground -- his reason. But maybe if you could get into it  
19 a little quicker here.

20 THE WITNESS: Yes, sir. Yes, sir.

21 And as the FDA has recently indicated, these  
22 medicines. It's not safe --

23 MR. RAMSEYER: Your Honor, I'd object to what the  
24 FDA's recently indicated. The events in question are a  
25 certain time period.

1 THE COURT: Yeah. Just explain why you FedExed  
2 prescriptions to people.

3 THE WITNESS: It's not safe for people to suddenly  
4 stop these medicines. And if they were not able to come to  
5 the office, we would do a telemedicine visit over the phone.  
6 It would be documented. And in those situations, their  
7 medicine would be FedExed, many times without payment. In  
8 some cases they did pay later. In some cases they paid over  
9 the phone with a credit or debit card. But, again, this was  
10 inside the context of they were being seen monthly. And then  
11 on occasion this circumstance would arise where they couldn't  
12 be there or the office might be closed and those prescriptions  
13 were FedExed to them.

14 BY MR. WILLIAMS:

15 Q. Okay. Was there a -- what was your thought process as  
16 far as the prescriptions getting to the parties?

17 A. Again, for a brief period of time when I first started my  
18 practice in the fall of 2015 and the first part of 2016, I  
19 trusted people I should not have trusted. And I know that  
20 now, and I was believing the best in people that they were  
21 doing what they told me they would do and from conversations  
22 that -- you know, most of which are not reflected in those  
23 text messages. And I -- I trusted people to do these things,  
24 and I shouldn't have trusted them.

25 Q. Okay. It's your understanding that if someone took a

1 prescription to a pharmacy they would have to be the one to  
2 take it?

3 A. That is -- I mean, in light of what Mr. Tom Hayes  
4 testified to earlier today, I mean, that's -- those are --  
5 there are certain exceptions where hospice patients and people  
6 that are bedridden or recently discharged from the hospital  
7 don't have to go. But my understanding is typically the  
8 pharmacy practice is that medications are dispensed to the  
9 person that they're prescribed to.

10 Q. Okay. Now, there's been evidence of pre-signed scripts  
11 and stuff. Tell the jury about that.

12 A. Well, there was a prescription pad with signatures that I  
13 had pre-signed in my office. This was a practice I learned  
14 when I worked at Bluestone. The medical director there,  
15 Dr. Bird, he would be -- he had two different clinics.

16 MR. RAMSEYER: Your Honor, I'm going to object to  
17 what somebody else did.

18 THE COURT: Well, I'm going to overrule the  
19 objection. Go ahead.

20 THE WITNESS: Okay. Dr. Bird worked at -- the rural  
21 health clinic I was working at had more than one site in the  
22 Princeton area in West Virginia. So he would leave some  
23 pre-signed prescriptions, and it was typically for either  
24 emergencies or situations where we -- you know, for his  
25 patients if you needed to order tests or studies. And if I

1 was out of the office and a patient needed blood work done at  
2 the ER or other tests or studies ordered, that was -- a signed  
3 prescription, if you take that into a hospital, to a hospital  
4 lab, that's the fastest way to get that test done and most  
5 likely approved by insurance where they'll pay for it.

6 THE COURT: So I'm not sure -- why did you pre-sign  
7 prescriptions? What's the reason?

8 THE WITNESS: That was the reason. That was the  
9 primary reason, Your Honor.

10 THE COURT: No. I didn't follow the reason. If you  
11 could repeat the reason you did it.

12 THE WITNESS: Right. So if I was not in the office  
13 and I needed -- if I was not in the office and there were  
14 patients coming to the office that day and I wasn't there and  
15 there was a medical need for a test to be done, that was the  
16 fastest way for that test to be ordered.

17 THE COURT: So you mean the prescriptions that you  
18 signed were only for tests, not for narcotic drugs?

19 THE WITNESS: Those -- those empty -- the empty  
20 prescription pad was primarily there for tests. There were  
21 circumstances and emergencies, as I was saying with Dr. Bird  
22 and then also in my case, where a change in patient medication  
23 would occur where they didn't tolerate a medicine, they had to  
24 be changed to a different medication, and that allowed for  
25 that process to occur quickly while the patient was still in

1 the office.

2 THE COURT: And you weren't there and didn't --

3 THE WITNESS: Correct. This is --

4 THE COURT: -- patient --

5 THE WITNESS: -- this is for patients that are  
6 ongoing chronic patients that are in the office regularly.

7 This was on a rare occasion if I wasn't in the office and this  
8 change needed to happen immediately.

9 THE COURT: So a patient would come in and tell  
10 whoever was behind the counter, I want you to change my  
11 prescription, or, I need another prescription, and that person  
12 would fill it in and give it to them?

13 THE WITNESS: That is completely not correct. What  
14 would --

15 THE COURT: Okay. So I -- again, I'm just trying to  
16 explain this for the -- for you to explain it to the jury.

17 THE WITNESS: Yes, sir.

18 THE COURT: Because I don't understand it. Maybe  
19 they do.

20 THE WITNESS: Right.

21 THE COURT: Why did you fill out signed blank  
22 prescriptions for narcotic -- that were to be used for the  
23 prescription of narcotic medication?

24 THE WITNESS: So, again, these are for emergency  
25 situations where --



1           THE COURT: But, like, what would be an emergency  
2 situation?

3           THE WITNESS: So if I wasn't at the office and I was  
4 able to have a telemedicine visit with an established  
5 patient -- this is an established patient that's already in  
6 ongoing treatment in my facility. They're not a new patient.  
7 This isn't someone just randomly walking in. We didn't see  
8 walk-ins. This is an established patient that's already on  
9 treatment. If they were intolerant to their medicine -- in  
10 most cases the prescriptions they received were post dated, or  
11 they had a may-fill date on them already in their chart.

12          THE COURT: So you're saying that in all of these  
13 cases where you had your -- somebody on your staff fill in the  
14 prescription, a blank prescription that you had signed, you  
15 had -- you had a teleconference with them? In other words, a  
16 FaceTime conference over the phone with the patient --

17          THE WITNESS: There was --

18          THE COURT: -- and then you told the count person to  
19 go ahead and do it?

20          THE WITNESS: There was a telemedicine conference  
21 with the patient and then there was also a phone conversation  
22 with Mr. Wilson. This was never -- nothing like this ever was  
23 handled at the front desk in any way, shape, or form. This  
24 was all done in the back with exam rooms and within a standard  
25 process that we followed. And this was rare. This -- but

1 this was -- it was in place so that if a patient's medication  
2 needed to be changed -- like Ms. Fisher with her gastric  
3 bypass, her medicine had to be changed. If I hadn't been  
4 there that day, you know, her medicine needed to be changed at  
5 that point, and that was the --

6 THE COURT: All right. Thank you. Go ahead.

7 THE WITNESS: -- solution I came up with.

8 BY MR. WILLIAMS:

9 Q. Would you talk with the patients each and every time?

10 A. I -- as far as I can remember, there was never a visit --  
11 there was never a prescription issued for any medical purpose  
12 from my office without me first talking to a patient, either  
13 through a telemedicine visit or through a face-to-face visit.

14 Q. Now, did you counsel the patients about other alternative  
15 options other than medication?

16 A. Absolutely.

17 Q. Like what? Explain to the jury what those would be.

18 A. Well, we have that handout that I don't know if we found  
19 yet, but my goal was not to remain a chronic pain -- in the  
20 sense that my office started out as where I was treating these  
21 chronic pain refugees from West Virginia and Kentucky. My  
22 goal was to transform my practice into an integrative holistic  
23 office.

24 And I did provide some manipulative therapy, which  
25 is the osteopathic manipulative therapy that I mentioned

1 earlier, to some of these patients, the ones I felt it was  
2 safe on. But, you know, I would routinely counsel patients in  
3 regards to different research-proven methods, such as yoga,  
4 Pilates, acupuncture. And I had handouts that I would go over  
5 with the patients in regards to this, including stretching.  
6 And part of the initial pain intake where they would fill in  
7 previous treatments tried such as physical therapy and other  
8 modalities, TENS unit. I personally use a TENS unit for my  
9 back.

10 So there were other modalities that would come up in  
11 those initial visits and later on that we would discuss. I  
12 was very much an advocate for because if someone could have  
13 proper control of their pain without being on a controlled  
14 substance, that was absolutely a goal of mine.

15 Q. But would you do that with every patient?

16 A. I would. I would say with the initial patients in 2015  
17 and part of 2016, I hadn't developed that process completely.  
18 So I don't want to say every patient that I ever saw in that  
19 office received that type of counseling, but that was a  
20 substantial part of visits I would have with patients on  
21 followup as well as initial visits.

22 Q. Did you counsel patients on addiction?

23 A. Well, I did. That was typically in a discharge scenario.  
24 In the initial visit where opiate pain management -- in most  
25 of these patients' cases they came to me on very strong

1 narcotic opiate pain medications. So in that initial  
2 conversation they would be counseled in conjunction with the  
3 Opiate Provider Agreement, the contract between myself and the  
4 patient. I would counsel them in regards to the risks of  
5 substance abuse addiction, tolerance. Tolerance is not the  
6 same as addiction. Physiologic dependence, which is where  
7 your body develops a dependence on the opiate, but that  
8 doesn't necessarily mean that they're -- that you're addicted  
9 to the opiate. It just means that if you suddenly stop it  
10 you're going to go into withdrawal. And these things were  
11 discussed in the initial visit and then periodically as  
12 needed.

13 Q. When you did the telemedicine visits, what was your  
14 purpose for doing that?

15 A. I wanted to maintain contact with the patient, and I  
16 wanted to be able to assess how they were tolerating their  
17 medicine. That was one of the chief reasons for monthly  
18 visits was to, as rapidly as possible, decrease the amount of  
19 narcotic they were taking, if possible. It wasn't always  
20 possible. But, if possible, decrease the amount of narcotic  
21 quickly, get them converted over from immediate release  
22 narcotic medicine, like oxycodone 30 milligrams, and get them  
23 off those, which is why I was reducing doses on those, and get  
24 them to a stable extended-release medication that would give  
25 them better quality of life and better functionality and

1 hopefully less opiate narcotic in their system over a period  
2 of time.

3 Q. Was it a concern for the patients, their health?

4 A. Oh, I mean, certainly. Long term -- your long-term  
5 health and survival rate is improved the less drugs you have  
6 to take, period, whether it's narcotics or non-controlled  
7 drugs.

8 Q. When you were FedExing the prescriptions to people, what  
9 was your intent from that?

10 MR. RAMSEYER: Your Honor, it's been asked and  
11 answered.

12 THE COURT: Haven't we asked that question already?

13 MR. WILLIAMS: I was just asking whether it was his  
14 intent to help people or -- well, I'll withdraw the question.

15 THE COURT: Yes, sir.

16 BY MR. WILLIAMS:

17 Q. Now, how did you feel about your patients?

18 A. I did what I did because I really cared about them.

19 Q. Do you believe you were helping them?

20 A. Yes, sir.

21 Q. What did you base that on?

22 A. I mean, I based it on why I went into medicine to begin  
23 with, to -- to try to help other people have a better life and  
24 have a more productive life, better function. I lived for the  
25 stories from my patients where they were able to play with

1 their grandkids more and able to spend more time outside and  
2 able for them, you know -- the people still worked, be able to  
3 go to work and come home and take care of their family.

4 Q. You made a lot of mistakes in your practice.

5 A. I did.

6 Q. Okay. Were you deceived a lot?

7 A. Yes, sir, I believe so.

8 Q. From who all?

9 A. Several of the patients that we've discussed during this  
10 trial.

11 Q. That would be the Jessies?

12 A. Yes, sir.

13 Q. Darryl Williams?

14 A. Yes.

15 Q. Lora Kicklighter?

16 A. Yes, sir.

17 Q. Kovalski?

18 A. Yes, sir.

19 Q. Was it your intention to hurt anybody?

20 A. Never.

21 Q. Did you believe when you wrote these prescriptions, all  
22 of these prescriptions were written for a legitimate medical  
23 purpose and need?

24 A. Yes, sir.

25 MR. WILLIAMS: Thank you. That's all the questions

1 I have.

2 THE COURT: All right. Cross-examination?

3 MR. RAMSEYER: Yes, Your Honor.

4 **CROSS-EXAMINATION**

5 BY MR. RAMSEYER:

6 Q. You testified at length on direct that the most important  
7 thing is that physical exam where you get to touch that person  
8 and hold onto them; right? That's the most important thing;  
9 correct? That's what you said?

10 A. I'm not sure if I said it's the most important. It's  
11 certainly one of the more important aspects.

12 Q. Okay. And Deborah Reynolds, you never touched her, never  
13 saw her, did you?

14 A. In her situation, I did not.

15 Q. Okay. And you say it was an emergent situation. It was  
16 an emergency that you sent these prescriptions; correct?

17 A. That -- at the time that's what I was led to believe,  
18 yes, sir.

19 Q. So it was an emergency in October, November, January,  
20 February? It's a five-month emergency?

21 A. I made a very, very poor decision.

22 Q. Well, let me just ask you, is it within the scope of  
23 professional practice to mail Schedule II narcotics to a  
24 patient you never see and send them to somebody else? Is that  
25 within the scope of professional practice?

1 A. I haven't read the specific laws as it relates to that.

2 Q. You think that's legitimate?

3 A. I believe that the patient had a legitimate medical need,  
4 yes, sir.

5 Q. No. I asked you what you did. You believe what you did  
6 was legitimate, to send some patient you never saw and -- I  
7 mean, it could have been Tom Jones on the phone. It could  
8 have been -- it could have been anybody that you talked to on  
9 the phone, supposedly; right?

10 A. It was a female.

11 Q. Okay. It could have been any female on the phone, and  
12 you think that's a legitimate medical practice?

13 A. I would just simply say I believe a legitimate medical  
14 need was established.

15 Q. Okay. So 20 different people call up. They say, "Doc, I  
16 got this friend. They need pills. Can you send them to them  
17 for me? They're in really bad shape. They're hurting. Just  
18 mail them to me. I'll make sure they get them." That would  
19 be legitimate -- legitimate medical practice?

20 A. I don't believe I ever did anything like that.

21 Q. You did exactly that, didn't you? With Deborah Reynolds  
22 that's exactly what you did.

23 A. The scenario you described didn't sound like it was an  
24 emergency.

25 Q. Okay. If a patient -- so if a patient calls up and says,



1 "I've got a friend. It's an emergency situation." You've  
2 never seen the patient, but they need their Schedule II  
3 narcotics mailed to me. And they call you next month and say  
4 the same thing. And they call you the next month and say the  
5 same thing. You say that's legitimate?

6 A. I don't think it would be appropriate.

7 Q. It's not legitimate -- it's not for a legitimate medical  
8 need and it's not within the scope of professional practice,  
9 is it?

10 A. I believed it was for a legitimate medical purpose. I  
11 agree it was not an appropriate decision.

12 Q. Do we agree it's not within the scope of professional  
13 practice?

14 A. I agree it's not an appropriate decision.

15 Q. You're not going to agree with me. Just answer the  
16 question. Yes or no, was that within the scope of  
17 professional practice?

18 A. I don't think it was an appropriate decision.

19 Q. Can you give me a yes or no answer. Was it within the  
20 scope of professional practice to mail Schedule II narcotics  
21 to a patient you never saw on multiple months?

22 A. I believe they had a legitimate medical need.

23 Q. So you say yes, that would be legitimate?

24 A. I believe the patient that I was writing those medicines  
25 to, based on their medical records and based on the extensive

1 conversation I had with them, and ongoing conversations I had  
2 with them, that they had a legitimate medical need. I  
3 certainly disagree with my decision to do that.

4 Q. All right.

5 MR. RAMSEYER: Your Honor --

6 BY MR. RAMSEYER:

7 Q. I've noticed you've been looking at notes. Do you mind  
8 if I look at your notes?

9 A. I have no problem.

10 Q. All right. Sir, let me ask you a few questions. You  
11 first appeared in federal court on August 15th of 2017; is  
12 that right?

13 A. August 15th?

14 Q. Yes, Monday.

15 A. Yes, sir, I believe so.

16 Q. And you first started practice in Martinsville about  
17 August 20th, 2017, something like that? Excuse me -- 2015,  
18 August 20th of 2015?

19 A. It was the last days of August. I'm not sure of the  
20 date.

21 Q. In any event, August of 2015?

22 A. At the end, yes, sir.

23 Q. So you were in business in Martinsville for about two  
24 years; is that right?

25 A. I maintained an office there, yes, sir.

1 Q. And during that two-year time period you wrote over 9,000  
2 prescriptions for Schedule II drugs; correct?

3 A. I have not added up the numbers on that.

4 Q. Well, if you look at the PMP, which doesn't include all  
5 of them, it shows 9,000 prescriptions for controlled  
6 substances.

7 A. If that's what the numbers indicate. I'm sure that's --

8 Q. And over half a million pills, units of controlled  
9 substances; does that sound right?

10 A. If that's what the numbers indicate, I'm --

11 Q. Okay. Now, did you take the Hippocratic Oath when you  
12 graduated from your med school?

13 A. I did not. We actually recite the Osteopathic Oath, but  
14 it's very similar to the Hippocratic Oath.

15 Q. And the first thing is do no harm; right?

16 A. That -- I'm not sure if that specific phrase is in our  
17 oath. I'm sure the spirit of that is contained in there.

18 Q. Things like, if you don't know what you're doing, don't  
19 do anything; right?

20 A. I don't know if that's my understanding of that.

21 Q. That's what it means, doesn't it? The first thing is  
22 don't do any harm. Sometimes when you do things to people,  
23 it's worse than doing nothing. That's what it means, doesn't  
24 it?

25 A. I mean, in my understanding of it, it can be true in both

1 senses of withholding action and also whether or not to  
2 proceed.

3 Q. Okay. Well, let me ask you this: All the prescriptions  
4 that have been entered into evidence in this case, you signed  
5 them; right?

6 A. Correct.

7 Q. You authorized them; right?

8 A. As -- I mean, I don't know that I've reviewed every  
9 prescription in evidence. But, I mean, if I was prescribing  
10 someone controlled substances from my office, it was for a  
11 legitimate medical need.

12 Q. That wasn't my question. Did you sign all -- did you  
13 authorize all the prescriptions that are in evidence, all the  
14 ones -- all the counts that you're charged with?

15 A. I mean, as far as I know. Like I said, I haven't  
16 reviewed every prescription that you have in evidence. In  
17 fact, I don't think I've actually reviewed the hard copies of  
18 that.

19 Q. All right. So -- all right. So, Dr. Smithers, let's go  
20 back to this pre-signed script pad. All right? That's  
21 against the law; right?

22 A. I -- I don't know.

23 MR. RAMSEYER: May I approach the witness,  
24 Your Honor?

25 THE COURT: Yes, sir.

1 BY MR. RAMSEYER:

2 Q. I'm going to show you Title 21, Code of Federal  
3 Regulations. It's manner and issuance of prescriptions. It  
4 says a prescription's supposed to be signed and dated the day  
5 it issues; correct?

6 A. Yes, I believe that's what it's indicating.

7 Q. All right.

8 A. Do you want me to read it?

9 Q. You didn't do that, did you, because you signed it ahead  
10 of time and just left it there at the office; correct?

11 A. In certain circumstances, yes.

12 Q. And you had no idea that somebody else had just written  
13 prescriptions out and given them to people?

14 A. I was religiously checking the prescription monitoring  
15 database. I would have realized that fairly quickly. I ran  
16 self-checks quite often.

17 Q. You said the reason you kept them there was so if  
18 somebody came with gastric bypass medication needs that  
19 Wendell could give them a prescription.

20 A. I'm sorry. I don't understand.

21 Q. On your previous testimony -- you just testified a few  
22 minutes ago. You said the reason you left a pre-signed  
23 prescription pad in your office was so if a person came by and  
24 they needed new gastric bypass medication or they had run out,  
25 Wendell could write it in and give it to the patient. That's

1 what you said.

2 A. No. Respectfully, Ms. Fisher had a gastric bypass. And  
3 what I was indicating was that for people that had an  
4 immediate need to have a change in medical therapy, that would  
5 allow for that to happen quickly so that they could hopefully  
6 fill their medication on their way home.

7 Q. So what kind of medication are you talking about?

8 A. In this case, it would be typically their controlled  
9 substance medication.

10 Q. Well, it would be the only thing; right? Schedule II  
11 narcotics?

12 A. They were also written for other medications such as  
13 SSRIs, medicines for nerve pain such as Neurontin, muscle  
14 relaxants.

15 Q. Exactly. All those pills you don't need a prescription,  
16 do you? Everything else, except a Schedule II, you can call  
17 the pharmacy. You could have called the pharmacy and sent the  
18 prescription in that way; correct?

19 A. With C-II narcotics I'm not sure if that would have --

20 Q. That was my point. Everything except Schedule II  
21 narcotics you can call in to the pharmacy.

22 A. Okay.

23 Q. All the other drugs, you could have just called them in?

24 A. Well, there was an emergency procedure for faxing C-II  
25 prescriptions in. Then you have to mail the original in. So

1 you have to bring the prescription. This happened on a few  
2 occasions. I had to write the prescription and then fax it to  
3 the pharmacy so that it would be filled by the time the  
4 patient drove through the pharmacy there. But they couldn't  
5 start filling that medication or process it until they had the  
6 actual -- or at least a photocopy of the prescription through  
7 a fax, and then that allowed them to proceed.

8 Q. So, Dr. Smithers, again, my original question was,  
9 everything except a Schedule II could be called in to the  
10 pharmacy; correct?

11 A. I believe that -- I mean, yeah. There had to be some  
12 type of paper document. I mean, I think there's also an  
13 electronic way to transmit them now.

14 THE COURT: Doctor, you can explain, but first, why  
15 don't you answer the question.

16 BY MR. RAMSEYER:

17 Q. Isn't it true that everything except the Schedule II  
18 controlled substance could be called into the pharmacy by a  
19 doctor?

20 A. Yeah. I think that's probably accurate.

21 Q. Okay. And so the only thing these prescriptions were for  
22 were for Schedule -- these pre-signed prescriptions, they were  
23 for Schedule II narcotics; correct? That's why you had them  
24 there?

25 A. They were for emergency tests that might need to be

1 ordered for patients that came in that were sick or that had  
2 other conditions. And if I wasn't there to write that  
3 prescription, then those tests couldn't be ordered that  
4 quickly. And then in certain emergency situations where  
5 patients' medicines were changed at my direction, or I had  
6 talked with the patient and made a medical decision on  
7 changing their therapy, that would allow for immediate -- an  
8 immediate change in their medical therapy.

9 Q. But you agree it's against the law to do that; correct?

10 A. I'm not sure. I mean, that's --

11 Q. I just showed it to you. You just read it and said it  
12 was.

13 A. Is that statute or is it an instruction, or...

14 Q. It's the Code of Federal Regulations, Title 21.

15 A. Okay.

16 Q. Code of Federal Regulations --

17 A. If that's --

18 Q. -- 36.05.

19 A. If that's what it says, I mean --

20 Q. It's kind of a basic tenant for physicians. Because  
21 physicians know you don't pre-sign prescription pads and leave  
22 them in your office. You knew that; correct?

23 A. As I testified, I worked with Dr. Bird. He was a medical  
24 director at the clinic that I worked at. That's where I  
25 observed that practice. And most of what we learn about the



1 controlled substances that we deal with and prescribe we learn  
2 from other doctors that we work with. We don't ever get a  
3 class on the Controlled Substances Act or get a class in the  
4 law.

5 Q. Okay. So, Dr. Smithers, let me ask you this: Did you  
6 ever see Deborah Reynolds as a patient?

7 A. I saw her as a patient through a telemedicine visit.

8 Q. You saw her on the telemedicine visit. You saw her face  
9 on a telemedicine visit, Deborah Reynolds?

10 A. It was telemedicine in the sense that it was a phone  
11 conversation.

12 Q. So you didn't see her, did you? You never saw her?

13 A. I did not.

14 Q. You never had a face-to-face -- I mean, you never had an  
15 in-person encounter with her?

16 A. I did not.

17 Q. Is that correct?

18 A. Yes, sir.

19 Q. And Darryl Williams paid you for the prescriptions you  
20 issued for Deborah Reynolds -- in Deborah Reynolds's name;  
21 correct?

22 A. I'm not sure. She may have paid over the phone. I'm not  
23 sure exactly how her office visit fee was paid for --

24 Q. Well, you know that --

25 A. -- at any given time.

1 Q. -- the text messages we've been showing in court --

2 A. Yes, sir.

3 Q. -- there was the one that you had the 18 different  
4 initials that you sent to Darryl Williams and you say, "18 x 3  
5 = 54." That means those 18 people you wrote prescriptions  
6 for, "18 x 3" is the \$300 per visit, and "54" is \$5400.  
7 That's what you told me; correct?

8 A. That was a one-time issue that did occur.

9 Q. Okay. And Deborah Reynolds was one of those 18 people;  
10 correct? She's DR?

11 A. I don't have that information in front of me. It's  
12 possible.

13 Q. Okay. So does that refresh your memory that when Darryl  
14 Williams wired money to you and your wife, some of that money  
15 was for Deborah Reynolds's prescriptions?

16 A. It's possible. I don't know.

17 Q. Okay. And you charged 450 for an initial office visit;  
18 right?

19 A. So it -- it's somewhat misleading to say it that way  
20 because Mr. Wilson worked for PPPFD. So it was actually a  
21 split payment. That would be the total, but I believe \$75 was  
22 the fee to pay for those services that went directly to the  
23 Physicians, Patients, and Pharmacists Fighting Diversion, that  
24 company that he worked for, and then the remainder of that was  
25 the office fee.

1 Q. The fee was 450, 375 to you, 75 to Wendell Wilson; is  
2 that right?

3 A. To PPPFD.

4 Q. Well, Wendell Wilson was PPPFD; right?

5 A. Well, Mark Radcliff owned the company. My understanding  
6 was Mr. Wilson was an employee of the company.

7 Q. Okay. At your office, physically the way it worked, when  
8 450 came in, you took 375. Wendell Wilson took 75; correct?

9 A. That was -- that's how the receptionist, I think,  
10 separated the money, yes.

11 Q. That's what you told the receptionist to do; correct?

12 A. That's what they were supposed to do as part of managing  
13 and keeping the funds separated. Yes, sir.

14 Q. All right. Did Peter Bodai come up with the idea of you  
15 getting 375 and Wendell Wilson getting 75? Was that his idea?

16 A. I don't believe so.

17 Q. That was your idea, and you told him to do that; correct?

18 A. The idea was -- kind of came about through negotiations  
19 with PPPFD as to what their fee would be. And then we -- I  
20 mean, it was over a period I think of a few weeks to figure  
21 out what would be the best way to keep those funds separate so  
22 that it would make it easier for Mr. Wilson to make deposits  
23 and for me to make deposits.

24 Q. Okay. So you and Wendell Wilson worked it out, and you  
25 told Peter Bodai what to do; correct?

1 A. I believe so. But, I mean, the negotiation wasn't just  
2 with Wendell. It was also with the rest -- mainly with  
3 Mr. Radcliff as well.

4 Q. But, in any event, on the "3 x 18 = 54" those patients  
5 never came in for that -- for those prescriptions; correct?

6 A. I don't believe that's accurate. I believe a number of  
7 those patients came into the office. I would have to -- I  
8 mean, I don't know. There were several circumstances where  
9 there were text messages indicating payment and I had already  
10 seen those patients in the office.

11 Q. This is one of them because you got the FedEx where you  
12 FedEx the prescriptions, you FedExed 18 people's prescriptions  
13 to Darryl Williams; correct?

14 A. I don't know that that's true. I'd have to see those.

15 Q. Well, you've seen them repeatedly. We've gone over them  
16 several times.

17 A. I've seen quite a few different pages of evidence in this  
18 trial.

19 Q. All right. So assume the evidence is that you FedExed  
20 those 18 people's prescriptions to Darryl Williams, and he  
21 wired the money to you, \$5400. Did Wendell Wilson get a cut  
22 of that?

23 A. I don't know. I believe our contractual agreement was  
24 only for patients that screening services were provided for in  
25 the office. So in the event that patients didn't come, that

1 was -- we had forms to keep track of that. So if there was a  
2 circumstance where we received payment in that way and the  
3 patient had actually come in the office, then there would  
4 be -- that fee would be divided. \$75 would go to PPPFD.

5 Q. I'm talking about the 18 scripts you mailed to Wendell  
6 Wilson at one time to the -- in the text messages. You sent  
7 those e-mails -- or you sent those prescriptions to him. He  
8 wired you \$5400. Did Wendell get a cut of it? That's all I'm  
9 asking.

10 A. Right. I don't know. Because I don't know if any of  
11 those patients were seen in the office. And if patients came  
12 into the office and they didn't -- and they weren't seen -- or  
13 if they were seen, then -- and they didn't pay, which occurred  
14 quite a bit, then I would actually cover their fee for PPPFD,  
15 and then whatever they paid after the fact, that would be  
16 covered -- or I would basically be refunded that money.

17 Q. I'm going to actually try one more time. Just answer my  
18 question. Did Wendell Wilson get a cut of the \$5400 that  
19 Darryl Williams wired to you and your wife?

20 A. I'm not sure. I'm not sure.

21 Q. Well, who would decide that?

22 A. It would be based on whether any of those patients had  
23 been seen in the office.

24 Q. Well, we know they weren't. So assume they weren't.  
25 Would he get the cut?

1 A. I don't feel comfortable making an assumption to answer a  
2 question.

3 Q. Okay. Well, did you see those patients?

4 A. Again, I'm being asked to make an assumption about  
5 something that I'm --

6 Q. I'm not asking --

7 THE COURT: The question to you, Doctor, is did you  
8 see the patients? And you need to answer that question.

9 THE WITNESS: If -- I'm not sure as to the question.  
10 I mean, because I'm not sure if I did see those patients on  
11 that circumstance or not.

12 THE COURT: So, you know, the alternative would be  
13 yes, no, or I don't know.

14 THE WITNESS: I don't know.

15 BY MR. RAMSEYER:

16 Q. All right. Thank you.

17 So Deborah Reynolds, you never saw her. But you  
18 charged Darryl Williams a \$450 first-time patient visit;  
19 didn't you?

20 A. If there's a record that shows that -- I mean, I'm not  
21 sure exactly. Like I said, Ms. Reynolds could have paid over  
22 the phone.

23 Q. The point is, you charged \$450. You never even saw the  
24 patient.

25 A. I spent significant time with her in reviewing her

1 medical records that came later.

2 Q. When -- you say you talked to her on the phone?

3 A. Yes, sir.

4 Q. And you say you talked to her a significant amount of  
5 time. You didn't have any medical records at that time, did  
6 you?

7 A. I did not. I had someone who I trusted at the time  
8 vouching for this person, and it was -- I was led to believe  
9 that this person would be coming into my office later that  
10 week or the following week at that time.

11 Q. Okay. And then it went on another month, another month,  
12 another month.

13 A. I made a significant error in judgment.

14 Q. And the reason -- one of the reasons you were sending  
15 prescriptions to Deborah Reynolds's name is you thought  
16 Deborah Reynolds was going to be an investor in a pharmacy you  
17 were trying to set up; isn't that the truth?

18 A. That is not in any way, shape, or form the truth.

19 Q. Did you think that --

20 A. I only treated patients that had legitimate medical need,  
21 and I only treated Ms. Reynolds because I believed she did  
22 have a legitimate medical need after I did investigation into  
23 her medical condition by talking to her.

24 Q. Okay. So Deborah Reynolds is in your phone as "Deborah  
25 Reynolds investor." So why did you have her in there as

1 "Deborah Reynolds investor"?

2 A. She may have indicated she wanted to invest in a project  
3 that never happened. There were never any investors, to  
4 my knowledge, that I --

5 Q. What was the project she wanted to invest in, according  
6 to you?

7 A. There had been some discussion, I think maybe that week,  
8 that, you know, people would either want to invest in the -- a  
9 lab or the monitoring system that we were using there in my  
10 office through PPPFD. And there also was a discussion at that  
11 time of possibly a pharmacy, and the people might want to  
12 invest in that as another --

13 Q. And you were thinking about investing in it as a pharmacy  
14 also; correct?

15 A. Well, this is true. I had thought about putting a  
16 pharmacy in my office at this time and had gone through some  
17 of the process of investigating that and ultimately didn't do  
18 it.

19 Q. Because, I mean, if you set up a pharmacy, you make a  
20 \$300 office visit, plus you make whatever they pay for the  
21 pills; right? That's what you were looking at?

22 A. No. I was trying to assist patients that were driving  
23 long distances and struggling. And I wanted them to have a  
24 consistent place where if their insurance was accepted that  
25 they would be able to fill their medication. There were many



1 situations where I would get reports where pharmacies were  
2 charging unbelievable amounts of money for a patient's  
3 medication. And in some cases, I -- I mean, I changed  
4 patients' medical treatment so that they would not have to pay  
5 as much for their medication because it was outrageous.

6 Q. Okay. So during the whole time we're talking about in  
7 this trial, August of '15, August of '17, did you maintain  
8 your clinic at the Center For Integrative Health at Smithers  
9 Community Healthcare Clinic doing business as Smithers  
10 Community Healthcare Clinic at 445 Commonwealth Boulevard  
11 East, Suite A, in Martinsville, Virginia?

12 A. Yes, sir.

13 Q. And the pictures we've seen of the clinic that have been  
14 introduced into evidence, that's your clinic; correct?

15 A. Yes, sir.

16 Q. And "SCH" in the text, that's you; correct?

17 A. That's Smithers Community Healthcare, yes, sir.

18 Q. But that's you. It was your phone; correct?

19 A. That was my old iPhone with the Tennessee area code, the  
20 865 area code, and I think that's how I still have it listed  
21 in my other iPhone.

22 Q. So it's your phone; correct?

23 A. Yes, sir.

24 Q. Also in those texts is Angela Smithers, your -- or Angel  
25 Smithers, your wife; correct?

1 A. That depends on which text message you're referring to.

2 Q. Where it said "AS".

3 A. I would say typically that's probably the case.

4 Q. And jasmithers@gmail.com, that's you in the text;  
5 correct?

6 A. That is my e-mail address, yes, sir.

7 Q. The texts that say "Joel Smithers," those are you too;  
8 correct?

9 A. I believe so, as long as the number matches my name.

10 Q. And the names in the text are, in fact, the names that  
11 you gave those people in your contact book; correct?

12 A. The names?

13 Q. Yeah. Like on the text where it shows "Darryl Williams,"  
14 that's because you have Darryl Williams in your phone with  
15 that phone number; correct?

16 A. Yes, sir.

17 Q. And that's true for all of those names; correct?

18 A. I mean, I would suppose that's the case.

19 Q. Now, let me show you Government's Exhibit 90, if we  
20 could. This has already been introduced into evidence.

21 MR. RAMSEYER: Please, can we have her computer?

22 THE CLERK: Yes.

23 BY MR. RAMSEYER:

24 Q. Is that your car?

25 A. Yes, sir.

1 Q. Is that the car you had at Smithers Healthcare?

2 A. Yes, sir. I still drive that car.

3 Q. Okay. And you -- at some point you bought an Escalade,  
4 didn't you, Cadillac Escalade?

5 A. For my wife, yes.

6 MR. RAMSEYER: And go to Exhibit 92.

7 BY MR. RAMSEYER:

8 Q. Those your credit cards that were found in the car?

9 A. Yes, sir.

10 MR. RAMSEYER: If we can go to 96.

11 BY MR. RAMSEYER:

12 Q. Those your drugs?

13 A. That is my backpack. Those are old, expired or returned  
14 patient medications.

15 Q. That you possessed; correct?

16 A. They were in my possession en route to the Henry County  
17 Sheriff's Office for disposal.

18 Q. Okay. And that was March 7th of 2017; right?

19 A. Yes, sir.

20 Q. And you hadn't practiced in West Virginia since July --  
21 or August of 2015; is that right?

22 A. Yes, sir.

23 Q. And you say that these were pills that you'd had for that  
24 period of time except for the ones -- the ones in baggies from  
25 Brenda Fisher.

1 A. Correct.

2 Q. You'd had them for about two years in your backpack;  
3 correct?

4 A. Correct.

5 Q. And that week you were going to take it to the  
6 Martinsville PD to get it destroyed; right?

7 A. I believe my research that the Henry County Sheriff's  
8 Department was where they --

9 Q. My question was -- you testified you had them for two  
10 years. But when the search came, coincidentally, that was the  
11 same week you were going to go get them destroyed. Is that  
12 what you testified to? It was going to be that week?

13 A. It did -- it happened at that time. Yes, sir.

14 Q. And were any of these pills going to go to a patient?

15 A. No, sir.

16 Q. Okay. Because you couldn't; right? They're all mixed  
17 together. People have touched them. You can't give those to  
18 a person, can you, legitimately?

19 A. I wouldn't -- I wouldn't want anyone to be given those.

20 Q. Right. And would you agree that the Schedule II drugs  
21 that were in that backpack were hydrocodone, hydromorphone,  
22 oxycodone, oxymorphone, methadone, and morphine?

23 A. That's entirely possible.

24 Q. Well, it's true, isn't it? You knew what was in there  
25 because you say you got them from people.

1 A. They were all mixed together. I didn't know exactly  
2 which drugs were in what bottle. They were just -- whenever I  
3 was practicing basically by myself in West Virginia, I didn't  
4 think about the flushing system that Mr. Wilson instituted in  
5 my office. And so I was just -- I didn't want to take  
6 patients' bottles because of potential HIPAA issues. So  
7 that -- I just had empty vitamin bottles. I take a lot of  
8 different vitamins.

9 Q. All right. So when you talk about Mr. Wilson's flushing  
10 system, it's not very complicated. It's pour it in the toilet  
11 and flush; correct? That's his flushing system?

12 A. He has a form that he edits that indicates the name and  
13 the dose of the medicine, as well as the quantity. And then  
14 on that form he -- it has a place for the witness, the patient  
15 to witness the destruction and then he witnesses it as well.

16 Q. Understood. But you didn't follow any of that; correct?  
17 You just took them from the patient?

18 A. I -- like I said, I was not aware of that system. That  
19 wasn't something that I was familiar with.

20 Q. But you could have just flushed them down the toilet on  
21 your own at any time; right?

22 A. I could have. I didn't.

23 Q. And you know from being in the medical profession and  
24 being familiar with the kind of patients you have, those are  
25 very valuable pills, aren't they, on the street?

1 A. Over the time that I practiced, I became aware when I  
2 discharged certain patients, people did indicate certain  
3 things about street value of certain medicines.

4 THE COURT: The question to you was did you know  
5 that these were valuable pills?

6 THE WITNESS: I knew in a subconscious sense. I  
7 mean, I wasn't -- I don't know what the value would be. I  
8 know that they're -- that people sell pills on the street. I  
9 don't know what the -- how to evaluate that.

10 BY MR. RAMSEYER:

11 Q. All right. Did you know hydrocodone, hydromorphone,  
12 oxycodone, oxymorphone, methadone, and morphine are all sold  
13 on the street? Did you know that?

14 A. I -- I am aware of that.

15 Q. You knew that in March when you had these pills in your  
16 car; correct?

17 A. Yes, sir, I probably was.

18 Q. Did you pay Peter Bodai in cash?

19 A. For -- yes, sir. Yes.

20 Q. All right. Always; right? He was always paid in cash by  
21 you?

22 A. As far as I know, yes, sir.

23 Q. And Juan Angel, was he paid in cash?

24 A. He was.

25 Q. And Wendell Wilson, was he paid in cash?

1 A. I was not his employer, so I'm not familiar with how he  
2 was paid. PPPFD, I mean, we had an accounting process for --  
3 I mean, because when patients' credit cards or debit cards  
4 would be charged, I -- we had a system where I would debit  
5 money, and that deposit went towards PPPFD to keep the  
6 finances separate.

7 Q. Actually, Wendell Wilson would take a bag of cash to  
8 deposit at the bank.

9 A. Yeah. He had a night deposit bag, I believe.

10 Q. Right. He -- so the 75 bucks he got, he got a cash bag;  
11 right?

12 A. As far as I know, he -- he did a total and accounting at  
13 the end of the day just like I did and had an accounting  
14 worksheet that he went through just like I went through an  
15 accounting worksheet.

16 Q. Let me try it a different way. Did you ever pay Wendell  
17 Wilson by check?

18 A. I wasn't paying him. This was a division of --

19 Q. It was an easy question. Did you ever pay Wendell Wilson  
20 by check?

21 A. No, sir.

22 Q. Did you ever pay him by direct deposit?

23 A. I don't believe I ever paid him.

24 Q. Okay. The same thing for Juan Angel and Peter Bodai.  
25 Did you ever pay them by check or direct deposit?

1 A. I don't believe so, no, sir.

2 Q. Did you have any trained medical personnel that worked at  
3 Smithers Community Healthcare in Martinsville?

4 A. When my wife worked there she was not a licensed nurse.  
5 I believe her license was a Certified Nurse Assistant.

6 THE COURT: Well, what's the answer to the question?

7 THE WITNESS: She was licensed as a certified nurse  
8 assistant.

9 THE COURT: The answer to the question, did you have  
10 any trained medical personnel?

11 THE WITNESS: I was trained medical personnel.

12 BY MR. RAMSEYER:

13 Q. Other than yourself, were there other trained medical  
14 personnel there?

15 A. I'm not sure what training Mr. Wilson had. I know he at  
16 least had CPR training, and he worked in a medical setting for  
17 years at that point.

18 Q. He worked at the Hope Clinic before; right?

19 A. He -- my understanding he worked in other clinics as  
20 well.

21 Q. Well, the only places Wendell Wilson worked in a medical  
22 setting was Hope Clinic pain clinic, before he went to you;  
23 correct?

24 A. I'm not sure. My understanding was he worked at a  
25 variety of medical clinics before he worked for me.



1 Q. And do you know why he left law enforcement?

2 A. I only know what I can remember that he told me.

3 Q. And you knew he was living in a car; right?

4 A. I did not.

5 Q. I mean, where did he live? Where was his actual house  
6 during the time period he was working at your clinic?

7 A. My understanding he was living with his wife and three or  
8 four kids in Tennessee.

9 Q. Murfreesboro, Tennessee; right?

10 A. That sounds correct.

11 Q. Which is near Nashville. It's about a six-hour drive, at  
12 least -- more than that, probably six or seven hours from  
13 Martinsville.

14 A. I don't know.

15 Q. Seem odd to you?

16 A. I -- I mean, it didn't -- I mean, I was trying to figure  
17 out why he did drive that far to work. But I wasn't -- I  
18 mean, he did a good job as far as I could tell and --

19 Q. Okay. Now, do you agree that over \$650,000 was deposited  
20 into your bank account in cash, wire transfers -- not wire  
21 transfers -- cash and credit transactions between the time  
22 period on that chart?

23 A. If that's what Bank of America says, I don't have any  
24 reason to dispute that.

25 Q. Okay. How much cash did you not deposit?

1 A. The contents of the glove box, which were earmarked to go  
2 to the IRS.

3 Q. That's about 20,000?

4 A. I think it was between 20 and \$30,000.

5 Q. Okay. What about the cash that was in your safe deposit  
6 box at your house?

7 A. That was life savings that had been saved over several  
8 years.

9 Q. Okay. So all the cash you got from Smithers Healthcare  
10 you put into your bank deposits?

11 A. With the exception of the money that had been saved to  
12 put into the IRS account that was -- that was --

13 Q. The 20,000-something in your glove compartment?

14 A. That was going and earmarked for the IRS. Yes, sir.

15 Q. So with exception of that. What about the money you paid  
16 Peter Bodai and Juan Angel, would those -- that didn't go  
17 through --

18 A. They were 1099 employees, independent contractors, and  
19 they accepted the responsibility of paying taxes on that  
20 income.

21 Q. Okay. But, in fact, you were their employer; correct?

22 A. They were hired temporarily. And, you know, it had been  
23 my experience that people that worked in that job were not --

24 Q. I'm just going to interrupt you a minute. Could you  
25 answer my question first and then if you want to explain it?

1                   You were their employer; correct?

2       A.     Yes, sir.

3       Q.     You told them when to come to work, what to do, when to  
4     leave; correct?

5       A.     Yes, sir.

6       Q.     Okay. But you paid them in cash because that way you  
7     wouldn't have to pay any taxes on them; correct?

8       A.     That was an arrangement that they -- they accepted. I  
9     believe in Peter's case requested. And Juan, I believe,  
10    requested as well.

11      Q.     Can you answer my question first and then explain it?  
12    Isn't the reason you paid them cash, one of the reasons, was  
13    so you wouldn't have to pay tax on it?

14      A.     I don't believe that's the reason at all, no, sir.

15      Q.     Okay. But anyway, the way you paid them, that was money  
16    you made at Smithers Community Healthcare Clinic that never  
17    went into your deposits; correct?

18      A.     That would be correct, yes, sir. It was still an expense  
19    that I believe was noted on our taxes, because it was an  
20    employment expense for the business.

21      Q.     Let's talk about how you ended up in Martinsville,  
22    Virginia. You graduated from medical school in 2012; correct?

23      A.     Yes, sir.

24      Q.     Then you did a residency internship at Blue Ridge  
25    Healthcare in Morganton? Was it a residency or internship?

1 A. A rotating internship, yes, sir.

2 Q. How much were you paid there?

3 A. Between 50 and \$60,000, I believe.

4 Q. 50 and 60,000 per year?

5 A. Yes, sir, I believe so, in that, I think.

6 Q. Did they pay you in cash?

7 A. I could be wrong about that. I was a W-2 employee there,  
8 so, no, sir.

9 Q. Did they pay you in cash?

10 A. No, sir.

11 Q. And you left there in what? June of -- June of 2014; is  
12 that right?

13 A. Yes, sir, I believe -- no, June of 2013, I believe.

14 Q. Actually, May of 2013.

15 A. May of 2013.

16 Q. And you left there -- you talked a little bit about what  
17 happened. But really what happened was you used your position  
18 as a doctor to try to get out of legal trouble; isn't that the  
19 truth?

20 A. I did. I made a horrible decision, and I lied to a  
21 police officer. It's the only time I've ever done that, and I  
22 paid a very high price for it.

23 Q. And what you actually did was, you got -- you were  
24 almost to the -- you were near the hospital and you got pulled  
25 over and the doctor smelled -- or the officer smelled alcohol

1 on your breath; correct?

2 A. Correct.

3 Q. And you blew a .082; correct?

4 A. I don't know. Officer Lloyd didn't -- he field sobriety  
5 tested me. He didn't show me what the test was.

6 Q. You got pulled over originally for speeding; correct?

7 A. That is correct, yes, sir.

8 Q. And you told the officer, "I'm a doctor. I'm on call.  
9 There's a stroke victim at the hospital that I'm trying to get  
10 to," didn't you?

11 A. I think -- it was either a stroke patient or a patient  
12 with pancreatitis. I'm not sure which. But I did make those  
13 types of statements.

14 Q. And it was a total lie; correct?

15 A. It was, yes, sir.

16 Q. You weren't on call.

17 A. I was not.

18 Q. There was no patient you were going to see.

19 A. No, I was not.

20 Q. It was just a way to get out of trouble; correct?

21 A. I was -- I was panicked. And I did not know what would  
22 happen with the Air Force having a DUI. I never had been  
23 pulled over with alcohol in my system, and I made a really bad  
24 decision.

25 Q. All right. So you had to leave there, as you testified,

1 in May of 2013; correct?

2 A. Yes, sir.

3 Q. And you ended up at an internship in Bluefield, West  
4 Virginia, Bluefield Regional Medical Center; is that correct?

5 A. Yes, sir.

6 Q. And how much were you paid there?

7 A. I believe it was about the same. Resident intern  
8 salaries are governed mainly by the Center for Medicaid and  
9 Medicare Services, I believe, and they don't change a whole  
10 lot, I don't believe.

11 Q. So it was 50 to \$60,000 per year?

12 A. I would believe that's probably correct.

13 Q. All right. Do they pay you in cash?

14 A. No, sir. I was a W-2 employee.

15 Q. Okay. And you left there in June of 2014; is that  
16 correct?

17 A. Yes, sir, that is correct.

18 Q. Why'd you leave there?

19 A. The -- I was informed at the end of May, around the first  
20 of June that the hospital board had voted to de-fund the  
21 internal medicine residency program. It's very rare, but it  
22 does happen. And the internal medicine residency position I  
23 was supposed to go into was -- no longer had any funding, and  
24 so I didn't have a residency to go into.

25 Q. So from June to -- through September 14, did you have a

1 medical job?

2 A. I don't believe so. I mainly did odd jobs.

3 Q. Okay. Then October of 2014. You started seeing patients  
4 at Bluestone Health Center in Princeton, West Virginia; is  
5 that correct?

6 A. October of 2014?

7 Q. Yes.

8 A. Yes, sir. Yeah, that's correct.

9 Q. And you left in April or May of 2015; correct?

10 A. Yes, sir, that's correct. Yeah, 2015.

11 Q. And when you left, you didn't have another job lined up,  
12 did you?

13 A. I did. I was going to open an urgent care, primary care  
14 practice in Dr. Bloom's clinic in Beaver, West Virginia.

15 Q. Well, that didn't open until June of 2015; right? You  
16 left in April.

17 A. It was going to open in May, but May is when they lost  
18 their appeal, I believe, for a chronic referred pain clinic  
19 license in Virginia. When they lost that appeal, it suddenly  
20 became not an option to have a practice there.

21 Q. Okay. Let me ask you this: At Bluestone, how much did  
22 you get paid?

23 A. I think I was paid -- I believe I was paid as a 1099  
24 employee twice monthly, 4 or \$6,000 twice a month.

25 Q. So 8 to \$12,000 a month?

1 A. I believe so, yes, sir. I'm sorry. I don't remember  
2 exactly which number --

3 Q. Around \$100,000 a year, approximately?

4 A. I think that -- I wasn't there for a full year, but I  
5 think it would have -- the annualized gross number would have  
6 been around 120.

7 Q. Okay. 120,000. But you left there. You said one of the  
8 reasons you left was people said you weren't basically seeing  
9 enough patients. You weren't working hard enough. Is that  
10 it?

11 A. That was not my testimony. I had a difference with the  
12 administrator of that clinic who wanted me to see more  
13 patients in a day, and I didn't feel I could safely see that  
14 many patients in a day. And we had -- I mean, we had talked  
15 along the way about, she -- you know, just kind of a regular,  
16 you know --

17 Q. There were some other issues, too, weren't there, between  
18 you and that administrator?

19 A. We got along well other than that.

20 Q. So the only issue was she wanted you to see more patients  
21 than you wanted to see?

22 A. I think we had a disagreement about maybe the time of the  
23 urgent care opening. We had an urgent care time that we had  
24 set up, and I wasn't always showing up for that right at 7:00  
25 or something, and we may have had a disagreement about that.



1 Q. So you're showing up late for work?

2 A. We had a disagreement about it.

3 Q. Well, were you showing up late for work?

4 A. I did at times, yes.

5 Q. And that was the reason why you left; correct?

6 A. I don't believe that was the reason why I left.

7 Q. Okay. So at that time, you're out of work. You're  
8 negotiating with the Hope Clinic. And just let the grand  
9 jury -- or the jury know. Mark Radcliff is one of the key  
10 figures in Hope Clinic; right?

11 A. My understanding is he -- Dr. Bloom was the medical  
12 director and Mr. Radcliff was the CEO, I believe, or the  
13 operations manager.

14 Q. Okay. So again, Mark Radcliff was CEO of Hope Clinic;  
15 correct?

16 A. Correct.

17 Q. And Mark Radcliff was a former district sales manager for  
18 Purdue Pharma; correct? The company that makes OxyContin?

19 A. I'm not familiar with Mr. Radcliff's employment history  
20 that well.

21 Q. Well, you've talked to Mr. Radcliff on several occasions,  
22 haven't you?

23 A. I have. I don't recall ever talking to him about where  
24 he's worked. I know he worked in finance in the Air Force.

25 Q. You knew he was a sales rep for a drug company at one

1 point, didn't you?

2 A. I don't believe so, no, sir.

3 Q. Okay. So he talks to you about opening a clinic in  
4 Beaver because -- or Beckley because the Hope Clinic is about  
5 ready to shut down; right?

6 A. He talked to me about opening an urgent care practice in  
7 his practice because his practice was about to be shut down.

8 Q. I asked you, isn't it true Mr. Radcliff was trying to  
9 find another doctor to send his Hope Clinic patients to, so he  
10 approached you about opening a clinic?

11 A. No, sir. I was opening my own practice so that I could  
12 continue to feed my family.

13 Q. Okay. So you opened that clinic called Priority Urgent  
14 Care on your own?

15 A. Yes, sir.

16 Q. No help from anyone else?

17 A. I think on my way out the door at Hope -- I mean, they  
18 may have provided me some lab sample bags, some paperwork. I  
19 think I may have gotten some office supplies. I mean, they  
20 didn't need the office supplies anymore, and --

21 Q. And explain that to the jury, too. On your way out the  
22 door from Hope, what does that mean?

23 A. Well, they were closing the clinic down. So, I mean --

24 Q. Had you worked at Hope?

25 A. No. I had set up an office there. I never saw a patient

1     there.

2     Q.    So you set up an office at the Hope Clinic.  And when it  
3     gets closed down, you take supplies with you; is that correct?

4     A.    I was given certain items.  I mean, they didn't need them  
5     anymore.  They weren't open.  That was my understanding.

6     Q.    Did you get anything else to help open Priority Urgent  
7     Care?  Any kind of financial backing?

8     A.    Not that I recall.

9     Q.    So you just had enough money saved up you could open this  
10    clinic on your own?

11    A.    It wasn't that expensive.  It was a 400-square foot  
12    office.

13    Q.    You need to answer my question.  You had enough money to  
14    open it on your own?

15    A.    I must have.

16    Q.    Nobody gave you any money; correct?

17    A.    I do not recall anyone giving me any money at the time.

18    Q.    You'd remember that, wouldn't you?  That's a pretty big  
19    thing, somebody giving you money to open a business?

20    A.    I would think I would.  I mean, I -- yeah.  I should  
21    remember that if it happened.

22    Q.    So did anybody give you any money to help you open  
23    Priority Urgent Care?

24    A.    Not that I recall.

25    Q.    Now, at Priority Urgent Care, you opened it on June 15th;

1 correct?

2 A. That sounds -- is that a Monday? It was a Monday.

3 Q. Okay. And let me back up. You talked about -- well,  
4 we'll get to that later.

5 Your Priority Urgent Care that you opened in  
6 Beckley, West Virginia, you were the owner; right?

7 A. Yes. Yes, sir.

8 Q. Okay. It was all cash; right?

9 A. I had not had a chance to set up --

10 Q. Again, just answer my question, please. It's all cash;  
11 correct?

12 A. Yes. It was -- it was -- I did have a Bank of America  
13 business account at that time, so we accepted all forms of  
14 payment, other than insurance.

15 Q. Well, you did not take insurance?

16 A. Correct, we did not take insurance.

17 Q. Cash, credit card was fine; right?

18 A. Yes, sir.

19 Q. So you open on June 16. You see 22 patients that day;  
20 correct?

21 A. That number sounds correct.

22 Q. And 22 of those patients all came from the Hope Clinic;  
23 correct?

24 A. I -- I don't know. I haven't reviewed those records in a  
25 long time.

1 Q. Well, you remember telling people that, that they were  
2 from the Hope Clinic?

3 A. Telling people?

4 Q. Yeah. There was a proceeding about this that you were  
5 involved in; correct?

6 A. I don't believe I was present for that proceeding. I --  
7 My -- I had an attorney that was present for that.

8 Q. Okay. Well, would you agree that you saw a lot of Hope  
9 Clinic patients on June 16th?

10 A. From my understanding, the patients -- I mean, I didn't  
11 ask patients where they -- the specific name of which pain  
12 clinic they came from in every instance. There were patients  
13 from a variety of pain clinics. My understanding there was at  
14 least three, maybe four pain clinics that had been shut down  
15 in Beckley all about the same time.

16 Q. Dr. Smithers, let me ask you about that. You made it  
17 sound like a pain clinic can't operate in West Virginia.  
18 That's not the truth, is it? All that -- all that West  
19 Virginia requires is that you be licensed as a pain clinic and  
20 that you be subject to inspection and that you follow the law;  
21 correct?

22 A. I think that's an oversimplification. That's part of  
23 licensure. As was witnessed with all the clinics that were  
24 shut down, it was made to be a very rigorous process, which is  
25 probably a good thing. At the same time, though, by

1 implementing that law resulted in thousands of patients losing  
2 access to care overnight.

3 Q. My question though is isn't it accurate that you could  
4 operate a pain management clinic in West Virginia so long as  
5 you registered and complied with the law and were subject to  
6 inspection; correct?

7 A. Those were the -- those were -- I mean, as far as I know,  
8 those are still the requirements.

9 THE COURT: Sir, is that -- it seems to me you could  
10 answer that yes or no or I don't know.

11 THE WITNESS: As far as I know --

12 THE COURT: Here's the three options: Yes, no, I  
13 don't know.

14 THE WITNESS: As far as I know, yes, that's --  
15 that's correct.

16 BY MR. RAMSEYER:

17 Q. So the only clinics that can't operate are the ones that  
18 aren't licensed, don't follow the law, or don't subject  
19 themselves to inspection; correct?

20 A. I don't know if it's been clarified, but at the time the  
21 law was passed, there was a great deal of ambiguity because  
22 the law said any -- any physician's office that saw more than  
23 50 percent in the 30-day calendar period that received  
24 anything so much as Tramadol -- or beyond Tramadol as a  
25 controlled substance and if they were over 50 percent in any

1 given 30-day period, they were considered a pain clinic. And  
2 if they hadn't applied for licensure, then they were  
3 considered an unlicensed pain clinic.

4 Q. Right. So all it was, they had to apply for a license,  
5 had to get it, had to be subject to inspection, and they had  
6 to follow the law; correct?

7 A. That -- that is -- yes.

8 Q. Okay. So you saw 22 Hope patients on June 16th at  
9 Priority Urgent Care. These are controlled substance  
10 patients; correct?

11 A. I believe they were treated with controlled substances,  
12 yes, sir.

13 Q. By you; correct?

14 A. After establishing a legitimate medical need, yes.

15 Q. And when you say "treated," you gave them a prescription  
16 for controlled substances; correct?

17 A. If that's what the record shows, yes.

18 Q. Okay. On June 17th and 18th, you actually -- you hired  
19 two registered medical assistants; correct?

20 A. I attempted to hire different people. I'm not sure.

21 Q. Well, you hired Kristin Medor and Ashley Harris; correct?

22 A. They did come and work for a couple days. I don't think  
23 they were there for more than a few days.

24 Q. They quit after being there for a day. Those were people  
25 with medical licenses, and they quit; correct?

1 A. I don't recall them quitting. I believe someone -- one  
2 of them got a job somewhere else. And I don't really remember  
3 the circumstances of why they -- they left.

4 Q. Well, getting a job somewhere else would involve quitting  
5 at your place; correct?

6 A. That is true, yes, sir.

7 Q. So isn't it true they both quit after a day, or at most,  
8 two days?

9 A. If that's what the record shows. I'm -- I don't  
10 remember.

11 Q. Okay. On June 17th, you saw 33 Hope patients, controlled  
12 substances patients; correct?

13 A. Again, it's been a long time since I've reviewed those  
14 records. If that's what --

15 Q. Does that sound right?

16 A. If that's what the record shows, that's correct.

17 Q. And then on Monday, June 22nd, you saw 26 Hope patients,  
18 controlled substances; correct?

19 A. Again, if the record reflects that.

20 Q. Well, I mean, does it sound right? I mean --

21 A. It does. It does. It does.

22 Q. -- you lived the experience. The Hope place was there.  
23 Were you giving controlled substances?

24 A. I was pretty overwhelmed. I mean, it does sound -- those  
25 numbers, there was really -- that's a lot of patients for me



1 to see in a day.

2 Q. Did you want the Hope patients? Did you want to see  
3 them?

4 A. I wanted to help people. I was not wanting to -- I mean,  
5 I was wanting to operate an urgent care. And these were very  
6 difficult patients in many cases to deal with.

7 Q. My question again is did you want the Hope patients?

8 A. I didn't -- I mean, I wanted to help people. I don't  
9 know what that means. I mean, I didn't have a desire for any  
10 specific patient other than to help people.

11 Q. Well, you said you didn't have any interest in running a  
12 pain care business, didn't you?

13 A. That was not the purpose of that office. The purpose of  
14 that office was hopefully to be an urgent care.

15 Q. Right. And you told the people that came that you didn't  
16 want to run a pain care business; correct?

17 A. That was -- that is correct, yes, sir.

18 Q. So on June 23rd, you'd been open for just about a week.  
19 The West Virginia authorities come. These licensing people  
20 that deal with pain clinics, they come to your office and they  
21 talk to you; correct?

22 A. Yes, sir, the people in this field and the people from  
23 OFLAC.

24 Q. From OFLAC; correct? in West Virginia?

25 A. Yes, sir.

1 Q. And they tell you, we want to -- we want to look at your  
2 records to determine whether you are operating a pain care  
3 business or not, pain management clinic; correct?

4 A. I believe they did make that request, yes, sir.

5 Q. And working at your window is Mark Radcliff's son;  
6 correct?

7 A. He was auditioning as an office manager, yes, sir.

8 Q. From Hope Clinic; correct? That's where he'd been?

9 A. I believe, yes. He had been there previously.

10 Q. And he gave the inspectors a fake last name; correct?

11 A. Later on I had found that out. I was not aware of that  
12 at the time.

13 Q. And so the OFLAC people talked to you, said, we'd like to  
14 look at your records, see if your operating a pain clinic.  
15 You tell them to come back with a subpoena; correct?

16 A. I don't believe that's how that conversation went.  
17 That's certainly the inference they took. You know, I was  
18 trying to operate an urgent care. I was not trying to  
19 maintain a doctor/patient relationship with these patients.  
20 And, you know, I felt it was unwarranted, you know, because I  
21 was trying to operate an urgent care.

22 Q. Do you understand my question? My question was: They  
23 asked to look at your records, and you said come back with a  
24 subpoena; correct?

25 A. I don't know that I said that. I told them if they

1 wanted to see medical records, my understanding of HIPAA and  
2 patient privacy is that they would need a court -- some type  
3 of court document to --

4 Q. Dr. Smithers --

5 A. -- assess those records.

6 Q. Did you let them see the records when they asked to see  
7 them on that day?

8 A. I did not, no, sir.

9 Q. And the reason you didn't was you didn't really have your  
10 records even ready for somebody to look at, did you?

11 A. I don't believe that was the reasoning at all. It was  
12 concern for patient privacy. And I was not familiar with the  
13 laws in regards to this state committee that was there in my  
14 office. And my understanding, as far as patient privacy,  
15 that, you know, there would need to be some type of a court  
16 order for them to have access to those records.

17 Q. So the OFLAC people come -- and earlier on direct  
18 examination you said you operated that clinic for two months.  
19 That's not really accurate. You operated that clinic for  
20 about a week; right? Because the day after the inspectors  
21 came, you -- that place was closed when they came back the  
22 next day to serve the warrant.

23 A. Well, one, I didn't know they had a warrant. Two, I --  
24 based on that interaction, they were very aggressive, and I  
25 took from the interaction that I needed some type of

1 representation. So I basically closed my practice on  
2 Wednesday to go find an attorney to represent me and hopefully  
3 come to some type of resolution with this state agency.

4 Q. And when they came back the next day, they found 72  
5 untested urine samples in the garbage from your clinic;  
6 correct?

7 A. I believe Mr. Radcliff, Josh, against what he had told me  
8 and what I had instructed him to do, which was to mail  
9 those -- because the last time I saw them they were in sealed  
10 packaging for UPS to go to the lab. I didn't find out about  
11 that until months later that they had found those in the  
12 dumpster.

13 Q. That's what happened; right?

14 A. But that is what happened.

15 Q. The inspectors were there one day. Come back the next  
16 day, you're gone. The urine is in the dumpster. That's what  
17 happened; correct?

18 A. Those are the facts, yes, sir.

19 Q. And then you opened a clinic over in Beaver, where Hope  
20 Clinic is in Beaver. You open a little clinic there out on  
21 Industrial Park Boulevard; correct?

22 A. I -- so because of the influx of patients at this  
23 facility --

24 Q. Okay. Can you just answer my question first?

25 A. Yes, sir. Yeah.

1           So I did -- I had a falling out with the landlord  
2 because of the patients that were coming in there. And so I  
3 did --

4 Q.    This is the place you already fled?

5 A.    This is the office that I agreed to leave I think in July  
6 at some point. We came to an agreement on that.

7 Q.    Wait a minute. Let's back up. So June 24th is when the  
8 inspectors came back and the office was abandoned. Where did  
9 you move your clinic to at that point? Did you move to  
10 Beaver?

11 A.    I thought that we saw patients out of that location in  
12 the medical arts building until July 4th weekend or the end of  
13 June.

14 Q.    Okay. So you're saying you went back there after you'd  
15 abandoned it?

16 A.    Well, I didn't abandon it. I just went to find an  
17 attorney. I didn't have enough staff and I didn't have  
18 another provider to see patients, so I had to close my office  
19 to go find an attorney.

20 Q.    But when you left on the 23rd -- when the inspectors come  
21 back on the 24th, there were no patient files there. They  
22 were gone; correct?

23 A.    Because I was trying to find an attorney, and I assumed  
24 that attorney would want to review my medical records in  
25 preparation for any type of dealings with this -- these

1 people.

2 Q. So you were so concerned about these patient files, where  
3 did you keep them?

4 A. I believe they stayed locked in the trunk of my car.

5 Q. Okay. So at some point you say you opened that back up  
6 then in Beckley?

7 A. As memory serves me, I believe that -- I believe my wife  
8 and I worked there out of that office up until July 4th  
9 weekend. I mean, that's what I remember. I could be wrong.

10 Q. And then you moved to Beaver; correct?

11 A. Yes, sir. About ten minutes down the road there I found  
12 another office space.

13 Q. Okay. And you opened that clinic when?

14 A. That probably would have been the first week of July.

15 Q. Okay. The first week of July?

16 A. Or it could have been at the end of June. I don't --  
17 yeah. I don't know the exact time.

18 Q. Okay. You heard Lora Kicklighter talk about where she  
19 saw you. That's where she saw you; right? that place in  
20 Beaver?

21 A. That office, yes, sir.

22 Q. Darryl Williams saw you there in Beaver?

23 A. Yes, sir.

24 Q. A bunch of people we've been talking about came to see  
25 you in Beaver; correct?

1 A. Yes, sir.

2 Q. And you gave them controlled substances; correct?

3 A. They were --

4 Q. Again, if you would just answer yes or no, please.

5 A. After the determination of legitimate medical need on my  
6 objective findings, they were prescribed some controlled  
7 substances, yes, sir.

8 Q. And then what made you -- you were only there, what, a  
9 month; correct?

10 A. Most of -- I mean, I was there most of August, so a  
11 month, month and a half, yes, sir.

12 Q. And you say you left there because if you'd stayed in  
13 West Virginia you would have to comply with the licensing laws  
14 on pain clinics; is that right?

15 A. I don't believe I said that. But if I wanted to see  
16 people -- so the premise of my urgent care was that I was  
17 seeing people and they were actually signing documents at  
18 their initial visit, which was their only visit with my urgent  
19 care was that it's a one-time visit. And I wasn't going to be  
20 able to, because of the law in West Virginia, see people on  
21 follow-up visits. And many of these patients, based on my  
22 medical assessment, needed ongoing care.

23 Q. Again, you could have stayed right there in Beaver,  
24 applied for a license as a pain clinic, comply with the law,  
25 and be subject to inspection; right? You could have done

1     that?

2     A.    And I would have still been four, five hours from my  
3     family, so --

4     Q.    Was it true you could have done that?  You could have  
5     stayed there and done that?

6     A.    I could have, yes, sir.

7     Q.    Instead, you closed; right?

8     A.    I did.

9     Q.    And you moved your practice to Martinsville, Virginia;  
10    correct?

11    A.    Yes, sir.

12    Q.    And that was in August of 2015?

13    A.    Yes, sir, the end of -- end of August of 2015.

14    Q.    And at this urgent care where you're prescribing  
15    controlled substances, you didn't give people, like, a  
16    seven-day supply or a ten-day supply in urgent care.  You gave  
17    them a 30-day supply, didn't you?

18    A.    It was -- I did.  And it was based on my medical judgment  
19    that, you know, these people were going to have an extended --  
20    you know, I mean, it's going to probably take them an entire  
21    month to find a new chronic pain facility clinic to treat  
22    them.  And, you know, I didn't think it would be me in any  
23    circumstance because, you know, recurrent patients visits  
24    would not -- you know, I wasn't -- I didn't want to be out of  
25    compliance.  And that -- the way West Virginia was doing



1 things at that time, to my knowledge, they still do things, is  
2 really, you know, there's really no leeway to try and help  
3 people that are in between certain types of management for  
4 their medical conditions.

5 Q. All right. So in West Virginia you were found to have  
6 knowingly operated an unlicensed pain clinic; correct?

7 A. That was the ruling. It's been appealed.

8 Q. Okay. Is that the reason you left West Virginia?

9 A. No, sir. I left West Virginia because I wanted to be  
10 closer to my wife and kids.

11 Q. Okay. And you knew that all the patients would come with  
12 you, wherever you went, didn't you?

13 A. I had no assurance of what patients would do, and I was  
14 hopeful that I could have a much quieter, calmer practice  
15 being away -- further away from that place.

16 Q. All right. So you talked a little bit about your Air  
17 Force background. How long did you stay in the Air Force?

18 A. I -- I believe I entered the Air Force in April of 2008  
19 or 2009. And as a result of leaving the -- or the internship  
20 program in Morganton, I did not realize at the time, but that  
21 actually resulted in an administrative discharge because they  
22 didn't want to wait until I finished the next internship, so  
23 they decided to end my scholarship with them.

24 Q. Did you have a Less Than Honorable Discharge?

25 A. It was an administrative discharge. I'm not sure -- I

1 haven't seen my DD-214. I'm not sure what it says.

2 Q. In any event, you didn't retire from the Air Force, did  
3 you?

4 A. It is a general discharge, if I remember correctly.

5 Q. You didn't retire from the Air Force, did you?

6 A. I was forced to retire from them, yeah. They -- at that  
7 point --

8 Q. You didn't retire. You were discharged.

9 A. Well, everyone that leaves or separates from the service  
10 is discharged.

11 Q. But some are honorable?

12 A. When you're separated from the military, you're  
13 discharged.

14 Q. So you consider yourself retired from the Air Force,  
15 that's why you put it on your letterhead that you're retired?

16 A. I don't know that it's on my letterhead anywhere. It's  
17 on my e-mail signature maybe.

18 Q. You sign your name as "U.S. Air Force, retired"?

19 A. It might be in an e-mail signature somewhere. It's not  
20 still in my e-mail signature, to my knowledge.

21 MR. RAMSEYER: May I approach the witness,  
22 Your Honor?

23 THE COURT: You may.

24 BY MR. RAMSEYER:

25 Q. This is a letter dated November 25th, 2015. It's from

1 you. Can you read to the jury how you signed your letter?

2 A. In this case -- in this case it was signed, "Joel A.  
3 Smithers, D.O., Captain, USAF Medical Corps, Retired."

4 Q. Thank you.

5 I'm going to show you what we've previously marked  
6 as Government's Exhibit 87. Whose handwriting is that?

7 A. It looks like my handwriting, sir.

8 Q. It's your handwriting. So you wrote a note saying, "Is  
9 Darryl Williams wearing a wire;" correct?

10 A. Yes, sir.

11 Q. All right. I'm going to show you Government's Exhibit  
12 49. Who wrote that?

13 A. I did.

14 Q. And it says, "For suspected wires: Without verification  
15 of your issues, I cannot help you." Correct?

16 A. Yes, sir.

17 Q. I'll show you what we've previously marked --

18 MR. RAMSEYER: And this will be just for the  
19 witness, please.

20 Exhibit 89, please.

21 BY MR. RAMSEYER:

22 Q. Dr. Smithers, did your clinic have a list of recommended  
23 pharmacies that you handed out to patients?

24 A. Eventually, yes, we did.

25 Q. Okay. Do you recognize this as one of those lists?

1 A. Yes, sir, I do.

2 MR. RAMSEYER: Your Honor, I'd move for admission of  
3 Government's Exhibit 89 at this time.

4 THE COURT: It will be admitted.

5 MR. RAMSEYER: Ask that it be published to the jury.

6 (Government's Exhibit 89 received.)

7 BY MR. RAMSEYER:

8 Q. Now, one of those pharmacies, you put Jeffersonville,  
9 Idaho, but it's actually Indiana; correct?

10 A. It's not Idaho. That is Indiana, yes, sir.

11 Q. Have you ever driven there? Have you ever been there?

12 A. I don't know that I have. I've driven through Indiana.  
13 I'm not sure.

14 Q. Have you been to Kentuckiana Pharmacy?

15 A. No, I've not been to that pharmacy. No, sir.

16 Q. Did you talk to the owner?

17 A. Yes, sir, I did.

18 Q. Is that Dr. Assad.

19 A. Yes, sir.

20 Q. Did you talk to him about having a supply of oxymorphone  
21 and other drugs for your patients?

22 A. I communicated with him as a professional.

23 Q. It's a simple question. Did you talk to him about having  
24 a supply of oxymorphone for your patients?

25 A. I talked to him in certain terms. I'm not sure if those

1 are specific words that I used.

2 Q. Did you and Darryl Williams send text messages back and  
3 forth about Kentuckiana and the supply and what they had?

4 A. If the record reflects that, then that's what happened.

5 Q. You've seen the record. It's your text messages, and  
6 you've seen them. Isn't that what happened?

7 A. Again, if that's what they show, then that's what it --  
8 that's what it represents. I'm not trying to be difficult. I  
9 just -- I've seen a lot of records over the past couple of  
10 months.

11 Q. Okay. So you had -- you say you had these drug screens  
12 at your clinic to try to guide your practice. Who supervised  
13 the urine screens for females?

14 A. Well, Mr. Wilson had his own system that, you know,  
15 obviously no one was female was on staff at the practice, so  
16 he had a system of listening and, as Mr. Angel testified, you  
17 know, looking at cloudiness and temperature. But nobody was  
18 able to be directly in the restrooms.

19 Q. Okay. And you didn't hire a woman to do that job, did  
20 you?

21 A. We didn't have -- I mean, as I recall --

22 Q. Let me ask you a question. Did you hire a woman to do  
23 that job?

24 A. We did not.

25 Q. Okay. Were there days you came in late to the office in

1 Martinsville?

2 A. Yes, sir.

3 Q. Were there days you didn't come in at all when patients  
4 were there?

5 A. That's possible, yes, sir.

6 Q. Well, it did happen; correct? Not just possible, there  
7 were days patients came to your clinic and you weren't there;  
8 correct?

9 A. Yes, sir, that is true.

10 Q. And there were days you didn't come in until the  
11 afternoon; correct?

12 A. Yes, sir, there were.

13 Q. And patients would be there at 7:00 or 8:00 in the  
14 morning, but you weren't there until late in the afternoon;  
15 correct?

16 A. There were situations where that occurred.

17 Q. And sometimes you would stay at the office 'til after  
18 midnight; correct?

19 A. Yes, sir.

20 Q. And sometimes you'd call the pharmacy and say, hey, I  
21 just sent some patients your way. They just got out the door.  
22 Can you keep the pharmacy open a little bit later until they  
23 get there?

24 A. I've heard testimony I think last week about that. That  
25 may have happened one time.

1 Q. Which pharmacies did you call and do that to?

2 A. If it happened, it would have not been very often.

3 Q. Which pharmacies did you call and ask them to stay open  
4 for your patients?

5 A. I don't recall. I don't -- I don't know who that would  
6 have been.

7 Q. So when those occasions when you weren't at the clinic  
8 and the patients were there, did they get their prescriptions  
9 filled?

10 A. In many cases, yes.

11 Q. In every case; correct?

12 A. It's possible. I don't know that it's true in every  
13 case.

14 Q. Dr. Smithers, every patient you saw got a controlled  
15 substance; correct?

16 A. I did some free sports physicals in my office, but, I  
17 mean, ongoing patients that were in my office, I believe most,  
18 if not all received a controlled substance at some point.

19 Q. Every patient you saw got a controlled substance other  
20 than those free physicals; correct?

21 A. I believe so, yes, sir.

22 Q. And when they came there and you weren't there, they  
23 still got their controlled substance prescriptions; correct?

24 A. After a rigorous process that included the screening with  
25 Mr. Wilson, a telemedicine visit.

1 Q. It's a simple yes or no.

2 A. Well, I believe the context is important for the jury.

3 Q. Okay. Can you answer my question first?

4 A. They -- they -- they did receive prescriptions for the  
5 medications they were on, and in many cases -- or in some  
6 cases, there was adjustments made to their therapy, both  
7 controlled and non-controlled substances, because most  
8 patients -- I believe almost all patients received a  
9 combination of different medicines.

10 Q. All right. And they paid the \$300 whether they saw you  
11 or not; correct?

12 A. That is true, yes, sir.

13 Q. And when you mailed the prescriptions, they still had to  
14 pay the \$300; correct?

15 A. In some circumstances -- there were several  
16 circumstances, like with the Jessies where -- I mean, they  
17 both had medical office bills with my office in excess of  
18 \$1,200 of monies owed. So there were several circumstances  
19 where I would do things to take care of those patients and  
20 they --

21 Q. Well, other than the Jessies, everybody else had to pay  
22 \$300?

23 A. There was other patients that didn't pay or they only  
24 paid shipping costs.

25 Q. Let's try it this way: For most of the patients and most



1 the prescriptions that you mailed to them, they had to pay the  
2 \$300; correct?

3 A. I believe so, yes, sir.

4 Q. The Jessies brought you a lot of patients; right?

5 A. I don't remember that that was the case, no, sir.

6 Q. You've seen the text messages where they're sending you  
7 patients and you're having to ask them, hey, this a first-time  
8 patient, or second-time patient, or having them tell you, no,  
9 these are patients you've seen before, Doctor. Do you  
10 remember all those?

11 A. I remember those specific messages, but I don't -- I  
12 mean, even from the documents in the past week, it seems like  
13 that was one or two patients. I'm not really --

14 Q. So you think the Jessies only sent you one or two  
15 patients?

16 A. I -- that's only -- that's all that I can recall from the  
17 past week. It's not --

18 Q. I'm not asking about last week.

19 A. I don't -- I don't recall --

20 Q. I'm talking about real life.

21 A. Yeah. I don't recall any specific number. I don't  
22 recall them sending maybe more than one or two that they  
23 referred, but --

24 Q. How many different crews did you have? We've been  
25 talking about crews. You had the Williams crew. You had the

1 Jessie crew. What other crews did you have?

2 A. I'm not sure I understand. I mean, I didn't know these  
3 people that engaged in this type of activity, so I'm not sure  
4 I understand what you're asking.

5 Q. Well, people that arranged for other people to come and  
6 see you.

7 A. There were a variety of patients that did that, and it  
8 didn't always -- it wasn't the same from month to month. I  
9 mean, I know people carpooled. And at the time I -- you know,  
10 in many cases I gave people the benefit of the doubt that that  
11 was due to the long trip and, you know, lack of funding and  
12 wanting to save on gas money.

13 Q. What about the Johnson-Rose crew? Do you remember them?

14 A. I -- I recognize the Johnson name, but I don't know of  
15 anybody that --

16 MR. RAMSEYER: May I approach the witness,  
17 Your Honor?

18 THE COURT: You may.

19 BY MR. RAMSEYER:

20 Q. Show you a text message. Ask you to read that. Can you  
21 read that out loud to the jury, please?

22 A. "Hope you slept well last night, sir. The Parsleys and  
23 Ralph Marcum, Jr., texted a bit ago and were stuck behind a  
24 wreck in Wytheville" --

25 THE COURT: Wait. Not so fast.

1 THE WITNESS: Oh -- oh, sorry.

2 I can't tell who this is from.

3 "Hope you slept well last night, sir. The Parsleys  
4 and Ralph Marcum, Jr., texted a bit ago and were stuck behind  
5 a wreck in Wytheville, so we will see the Johnson-Rose crew  
6 first."

7 BY MR. RAMSEYER:

8 Q. And that's from you first; right? that text message?

9 A. I -- I'm not sure.

10 Q. Well, it says that; right? Doesn't it say, "From Joel  
11 Smithers"?

12 A. I can't see where it says "from."

13 Q. "Sent." See, "Joel Smithers, sent"?

14 A. Okay.

15 Q. So who are you talking about? Who's the -- when you  
16 refer about the Williams crew and the Jessie crew -- who is  
17 the Johnson-Rose crew? Who are they?

18 A. I'm not -- I have a couple different patients that have  
19 the last name of Johnson. I know I had at least one patient  
20 with the last name of Rose. I don't -- I mean, I -- you know,  
21 I was very flippant in some of these text messages. I  
22 don't -- I don't really know who exactly I was referring to  
23 there.

24 Q. Sharon Mullins testified that she met you at Starbucks  
25 and you gave her a prescription for fentanyl. She was telling

1 the truth, wasn't she?

2 A. That -- that did occur.

3 Q. And that was in North Carolina; right?

4 A. That did occur, yes, sir.

5 Q. And that was in -- she paid you \$300 in cash; correct?

6 A. I don't recall. But if she testified that that is what  
7 happened, then I would say that that's probably what happened.

8 Q. She gave you 300 -- she handed you \$300, and you handed  
9 her a prescription; correct?

10 A. I believe I handed her the Brief Pain Inventory that she  
11 filled out, and then we discussed her medical situation.

12 Q. You're saying that you -- in the Starbucks parking lot,  
13 you had her fill out the Brief Pain Inventory?

14 A. I believe so, yes, sir.

15 Q. Okay.

16 A. I don't recall specifically, but, I mean, that form was  
17 filled out.

18 Q. Well, sometimes you filled out the Brief Pain Inventory  
19 after the fact, didn't you?

20 A. If it was a telemedicine visit, that would, in some  
21 cases, be done as I was talking to the patient and getting  
22 that information from them over the phone and going through  
23 that with them.

24 Q. Now --

25 THE COURT: Mr. Ramseyer, let me interrupt you.

1 Ladies and gentlemen, I'd like -- this is our last  
2 witness, and I'd like to finish today. I know this may be  
3 inconvenient for you to stay a little later, but I think it  
4 would save time. But you may need a little break right now.  
5 We've been going for a while. So we're going to take a short  
6 recess.

7 And let's push on, if we can, so that we can finish  
8 up and get you back into real life as soon as we can.

9 All right. We'll be in short recess.

10 (Proceedings suspended at 5:12 p.m. and resumed at 5:26  
11 p.m.)

12 (Proceedings held in the absence of the jury.)

13 THE COURT: All right. Are we ready for the jury?

14 MR. RAMSEYER: We are, Your Honor.

15 THE COURT: All right. We'll have the jury in.

16 (Proceedings held in the presence of the jury.)

17 THE COURT: All right. You may proceed.

18 MR. RAMSEYER: Thank you, Your Honor.

19 BY MR. RAMSEYER:

20 Q. Dr. Smithers, first, I took a look at the notes you were  
21 having before you. Isn't it true that when you talked to the  
22 jury about prescription opioids having a similar structure to  
23 endorphins, you had actually written out what you were going  
24 to say about that, the script?

25 A. These were just notes to refresh my memory last night

1 when I was preparing to possibly testify today.

2 Q. And the little diagram you drew, you actually got that on  
3 your notes; is that right?

4 A. I'm not an artist. I wanted to practice to be ready.

5 Q. You have sort of like stock answers, "Counselor, I'm  
6 confused." You had to write those down to know what to say?

7 A. I think a lot of these were notes from phone  
8 conversations with my dad and things that he mentioned to me,  
9 and I just wrote them down when I was the phone with him for  
10 about two hours last night.

11 Q. If we could look at VHU-338, please. It's on your  
12 screen.

13 A. Yes, sir.

14 Q. Okay. Whose handwriting is that?

15 A. For the -- it's my signature. The handwriting -- the  
16 handwriting is -- I believe it's Mr. Wilson's.

17 Q. Wendell Wilson's; correct?

18 A. I believe so, yes, sir.

19 Q. So this is one of those where you left a pre-signed  
20 script, and he filled out the information; correct?

21 A. That would -- there was probably a change in medication  
22 therapy that warranted --

23 Q. Can you answer my question, please?

24 A. Yes, sir.

25 THE COURT: Mr. Smithers, you can always explain,

1 but you need to answer the question first.

2 THE WITNESS: Yes, sir. Yes, that would be correct,  
3 and it was done probably when the, you know, urgent change to  
4 the patient's medication.

5 BY MR. RAMSEYER:

6 Q. Okay. And if there's, like, no Brief Pain Inventory done  
7 on that date, that would be an indication that really nothing  
8 happened other than the patient came in and got their  
9 prescription; right?

10 A. That's not necessarily true. I mean, days that I wasn't  
11 at the office there were procedures in place for those  
12 documents to be filled out. If there wasn't one filled out,  
13 I'm not sure why that would be the case. That would be very  
14 rare. And there would have been a telemedicine visit for this  
15 medication, especially if we were changing the medication.  
16 I'm the only person that would make a change to a patient's  
17 medicine, so...

18 Q. So the only time a prescription is changed, is you  
19 made -- it's all in your handwriting; correct?

20 A. I'm saying it's a change -- no. I'm saying it's a change  
21 that occurred as a result of talking to the patient and  
22 determining a new course of treatment based on information  
23 from the patient in regards to the medicine they'd been on the  
24 previous month and that necessitating a change to continue  
25 treatment.

1 Q. Okay. I'm confused. Is this a -- Wendell Wilson writes  
2 it out if there's going to be a change or if there's not a  
3 change?

4 A. So if -- if there's a change -- so if there's not a  
5 change, there's typically a may-fill date or a postdated  
6 prescription in the chart that I have written and that would  
7 be what the patient would receive if they -- if everything  
8 goes -- they go through the screening process, they go through  
9 the urine drug screen, they go through their pill counts and  
10 there's no issues, checking for needle marks. Then at the end  
11 of that, then that postdated, or predated, or may-fill date  
12 prescription would be issued. And that's if there's no  
13 changes to their therapy.

14 If there's a change that needs to be made after I  
15 speak with the patient or in the course of all the compliance  
16 screening, there is an issue with their compliance, they don't  
17 pass their pill count, their previous month's urine drug  
18 screen wasn't what it was supposed to be, if there was a  
19 compliance issue, then that's also going to necessitate a  
20 change in therapy.

21 Q. And so then Wendell will make the change?

22 A. No, I will make the change. I would speak with the  
23 patient after speaking with Mr. Wilson and gathering all the  
24 relevant information that I can, and then I will speak with  
25 the patient. In some cases, this did happen by phone.



1 Q. In some cases, it didn't happen at all. There were  
2 patients that didn't see you, didn't talk to you on the phone,  
3 and they got a prescription?

4 A. I don't know that that's true. It could have happened,  
5 but I don't know that that's true. If there was no change in  
6 therapy and for some reason I was completely out of pocket,  
7 couldn't be reached, that may have happened, but it would have  
8 been exceedingly rare.

9 Q. Okay. So all the prescriptions with Wendell Wilson's  
10 handwriting up there at the top, those are ones where you were  
11 not at the clinic; correct?

12 A. Again, I don't necessarily know. In some cases there may  
13 have been a situation where I directed him to fill out the  
14 information and then I signed it after he filled the  
15 information out.

16 Q. Well, that didn't happen, did it?

17 A. In some situations I believe it did.

18 Q. Okay. Would you agree that in 90-some percent of the  
19 prescriptions where it's Wendell's name -- I mean, Wendell's  
20 handwriting, you weren't there?

21 A. I don't have any data to agree or disagree with that  
22 statement.

23 Q. Okay. You don't have any idea how many times Wendell  
24 filled out prescriptions and you weren't there?

25 A. It was very rare. It was not a common occurrence.

1 Q. It happened all the time towards the end, didn't it?

2 A. Towards what end?

3 Q. There were weeks where you were there one or two days.

4 A. Well, we were only open three days a week, so...

5 Q. Okay. And there were weeks you were only there one or  
6 two days.

7 A. That was rare, but that did happen.

8 Q. There were prescriptions going out and you weren't  
9 talking to them on the phone; correct?

10 A. That is not correct.

11 Q. You talked to them all on the phone?

12 A. To my knowledge, most patients were -- did have some type  
13 of contact with me directly to confirm --

14 Q. If you could answer my question. Did you talk to all the  
15 patients on the phone before Wendell Williams -- Wilson filled  
16 out a prescription?

17 A. If there was a change in therapy and Mr. Wilson did  
18 this --

19 Q. I didn't ask that.

20 A. Well, you stipulated that he did. So if he did, in that  
21 case, I would have talked to the patient.

22 Q. No. The question, again, is, were there times Wendell  
23 Wilson filled out the prescription, you had already pre-signed  
24 the script a day or two before, and you didn't see the  
25 patient? You didn't talk to the patient?

1 A. I don't believe that any -- that would have ever  
2 occurred, no, sir.

3 Q. Okay. Now, you testified on direct that you -- you put a  
4 special notation on the prescriptions. Well, the reason you  
5 put that notation on there was to try to get the pharmacy to  
6 fill it; correct?

7 A. No, sir. It was there to provide the pharmacist with  
8 additional information that, after speaking with pharmacists,  
9 I found the more information that they had the faster they  
10 could do their job and determine legitimate medical need. And  
11 that that helped them do their job better and so that just  
12 became a standard practice of mine.

13 Q. Now, your medical files that you kept, did you write down  
14 what happened to that -- at your visits in your encounters?

15 A. In some cases I did and in other cases I did not.

16 Q. You're supposed to; right? A good doctor would do that;  
17 correct?

18 A. I should have done a much better job of maintaining my  
19 medical records.

20 Q. You agree a good doctor, a doctor doing what doctors do  
21 would keep track of what happened; correct?

22 A. I don't agree with the generalization. I do agree that I  
23 should have done a better job.

24 Q. And looking through your charts, you were -- you didn't  
25 really have any experience in pain medicine; correct?

1 A. I -- I did. I had education. I had worked with a few  
2 different pain specialists. I mean, I did not have the level  
3 of experience of a board certified specialist, no.

4 Q. And you really, really, really cared about your patients;  
5 correct? You really wanted them to get the best treatment  
6 possible; correct?

7 A. I -- I did.

8 Q. And so in the charts, will we find a lot of times where  
9 you've referred the patients to, like, a legitimate pain  
10 management clinic to help deal with the problem?

11 A. There were not many clinics back home where they could  
12 go. And the way that process would work, especially for those  
13 that --

14 Q. You need to answer my question. If we look through those  
15 charts --

16 A. That's -- that's not going to be found in the charts  
17 because with a lot of these patients, the types of insurance  
18 they had, those referrals needed to come from their primary  
19 care physician so that they could get coverage for those new  
20 referrals through their insurance.

21 Q. All right. Now, if a patient had, like, a real medical  
22 problem where they actually needed you to do something, would  
23 you deal with it?

24 A. I don't understand.

25 Q. If they had a real medical issue, like, not just that

1 they wanted pain pills but they had a real medical issue, just  
2 something normal people want to go to the doctor for, would  
3 you deal with it?

4 A. Every patient I treated at my office had a real medical  
5 problem, sir.

6 Q. Okay. So the answer is yes?

7 A. As far as I'm aware, yes, sir.

8 Q. And you felt like pain medicine with these high-powered  
9 narcotics was something you could do over the phone, not see  
10 the patient; right?

11 A. These were patients that are being seen month to month  
12 and this was on occasion within the 90-day period where they  
13 had been seen on a month-to-month basis where they would --

14 MR. RAMSEYER: I just want to show it to him.

15 THE WITNESS: -- where they would -- if they were  
16 not -- if we had no non-compliance issues and no changes in  
17 therapy, there were circumstances where -- where we would do  
18 what we could to try and help the patient.

19 BY MR. RAMSEYER:

20 Q. So, Dr. Smithers, if you'd look at this. This is the  
21 text message exchange between you and a patient; correct?

22 A. This does appear to be a text message. It's between me  
23 and a patient, yes, sir.

24 MR. RAMSEYER: Your Honor, I move that this be  
25 admitted at Government's Exhibit 108.

1 THE COURT: It will be admitted.

2 (Government's Exhibit 108 received.)

3 MR. RAMSEYER: If we can publish this to the jury.

4 BY MR. RAMSEYER:

5 Q. And that's an exchange between you and a patient;  
6 correct?

7 A. Yes, sir.

8 Q. It's yes or no.

9 A. Yes, sir, I believe so.

10 Q. I'll leave it up so everybody gets a chance to read it,  
11 actually.

12 Dr. Smithers, if any person comes into your clinic  
13 and has got an MRI, says they're in pain, said Advil doesn't  
14 work for them, you're giving them controlled substance; right?

15 A. No, sir. I disagree with the premise of your question.  
16 That is not what occurred. There were -- there was a time at  
17 my practice where I allowed people with medical records to  
18 come in. That practice quickly changed after I opened my  
19 practice in Martinsville and I began requiring patients to fax  
20 their medical records to me first so I could review those  
21 medical records and then make a determination whether I wanted  
22 to see them as a patient.

23 Q. All right. Now, again, it's really important that  
24 healthcare professionals work together; right?

25 A. Yes, sir.

1 Q. I mean, would you want -- as a doctor, you would want to  
2 know the whole story about your patient; correct?

3 A. Yes, sir. I tried to --

4 Q. You want to know what doctors they're going to. You want  
5 to know what prescriptions they're getting; correct?

6 A. Yes, sir.

7 Q. It's important so that one doctor doesn't do something  
8 that might affect the other doctor; correct?

9 A. Yes, sir.

10 Q. Pretty harmful to patient to withhold information from a  
11 healthcare provider; correct?

12 A. It could be.

13 MR. RAMSEYER: Can I have just a moment, Your Honor?

14 BY MR. RAMSEYER:

15 Q. Dr. Smithers, if we can go back to the Blakey Hurley  
16 exhibit.

17 While they're doing that, what does "PRN" mean?

18 A. As needed.

19 Q. So that means somebody's got that prescription, they can  
20 take it as needed; correct? When the prescription says "as  
21 needed" --

22 A. As needed in the context of the rest of the directions on  
23 the prescription, yes, sir.

24 Q. So if they have a prescription taken as needed, that  
25 means they take them when they think it's appropriate to take

1 it; correct?

2 A. In the context of the prescription's other directions.  
3 It's never just PRN and no other directions. It's PRN and  
4 other directions are given. As this example, every 8 to  
5 12 hours as needed for severe breakthrough pain.

6 Q. Okay. And this prescription is dated January 3rd, 2017;  
7 correct?

8 A. Yes, sir.

9 Q. And I'm just trying to understand again, does Wendell  
10 sign it if there is a change or if there -- I mean, does he  
11 write it out if there is a change or if there's not a change?

12 A. Typically, that would only occur if there was a change  
13 and the postdated or may-fill date prescription in the chart  
14 that was previously written by me could not be used because  
15 there was a change in therapy. So if there was a change in  
16 therapy, that prescription gets shredded and a new  
17 prescription has to -- has to be created to account for the  
18 change in therapy.

19 Q. All right. So you're saying every prescription that we  
20 see with Wendell Wilson's handwriting is going to be a change;  
21 correct?

22 A. I don't believe I've testified to that today.

23 Q. Well, is that true or not?

24 A. I can't say with absolute certainty that that is the  
25 case, no, sir. And this prescription I'm looking at now is in



1 my handwriting.

2 Q. Now, your practice the entire time you were there, as  
3 you've testified, every person got a controlled substance;  
4 correct?

5 A. At some point, I believe so, yes, sir.

6 Q. And you wrote a letter to somebody one time describing  
7 your clinic. Do you remember that?

8 A. Yes, sir, I do.

9 MR. RAMSEYER: And I'd like to approach.

10 THE COURT: Yes, sir.

11 BY MR. RAMSEYER:

12 Q. And I'd like you to read that, that first paragraph,  
13 please, of your letter that describes your practice at  
14 Smithers Healthcare.

15 A. All right. I wrote, "The Center For Integrative Health  
16 at Smithers Community Healthcare PC is to become the  
17 community's primary resource for integrative medical care in  
18 Martinsville, Virginia, as we serve adult patients with a  
19 holistic healthcare model and treatment options focused on  
20 improved function and health of the individual. This will be  
21 accomplished through a variety of modalities, including the  
22 application of osteopathic and internal medicine principles  
23 using medication and OMM, Osteopathic Manipulative Medicine,  
24 as well as alternative therapies where appropriate on a  
25 customized basis for each patient.

1 "I have regularly practiced OMM since medical school  
2 and continue to help patients regularly with this proven  
3 medical modality. A cornerstone of the practice will be  
4 strong advocacy for physical activity on a daily basis as the  
5 patient is able, including basic but vital activities such as  
6 walking, as well as other highly researched and recommended  
7 physical activity options such as yoga and/or Pilates. Our  
8 goals will be to educate patients regarding their health to  
9 facilitate improved outcomes manifested as improved daily  
10 functioning, which hopefully translates to improved quality of  
11 life."

12 Q. Okay. Why didn't you say, "I'm running a pain clinic"?

13 A. My intention in writing this was what I wanted my office  
14 to become.

15 Q. And it wasn't -- that's not what your clinic was, is it?

16 A. There are many things in this letter that I was doing at  
17 my office, as described in this letter, and was pushing it  
18 towards more of at the time it was drafted and written.

19 Q. Okay. Now, your patients paid \$300, and they got a  
20 prescription; correct?

21 A. No. They paid \$300 and went through a rigorous  
22 compliance program and had a medical office visit with a  
23 physician and had someone that was on 24/7 hour call.

24 Q. Okay. Let me ask you about this. So the payment was  
25 actually 225 to you; correct?

1 A. At one point, yes, sir.

2 Q. Seventy-five to Wendell; correct?

3 A. To PPPFD.

4 Q. PPPFD. And the \$75 was for that compliance stuff.  
5 Correct?

6 A. Yes, sir.

7 Q. Now, going back to my other question, it's important that  
8 you share information with -- between physicians. I want you  
9 to read a text message that you sent to Wendell, and let me  
10 show you -- and if you could read the part that's highlighted  
11 there to the jury as to what you sent to him about a patient.  
12 If you could read it out loud, please.

13 A. So "Wherever he -- wherever he is having increased or  
14 worsening pain, he needs to see his primary care provider and  
15 have at least X-rays done, as well as potentially a referral  
16 to orthopedics."

17 Q. And then what's your text message you say after that?

18 A. "At no point during any discussion with his primary care  
19 provider should he mention us."

20 Q. Yeah. Don't tell the primary care provider about us;  
21 correct?

22 A. That is not the correct context of that conversation.  
23 You're misconstruing it.

24 Q. "At no point during any discussion with his primary care  
25 provider should he mention us." That's what you said;

1 correct?

2 A. You're misconstruing the context of that conversation,  
3 sir.

4 Q. Well, I mean, the context is you didn't want him to talk  
5 to his primary care provider about you; correct?

6 A. This is in the context of trying to get our patient a  
7 medical procedure and referral approved through his insurance.  
8 And for that process to typically work the way it's supposed  
9 to, as I understand the text messages you're not having me  
10 read to the jury, that that context -- I haven't had a chance  
11 to review this whole page but that context is important for  
12 this conversation.

13 Q. Well, it was a simple question. Did you tell Wendell to  
14 tell the patient under no circumstances -- "At no point during  
15 any discussion with his primary care provider should he  
16 mention us"?

17 A. That's what's in that text message.

18 Q. Would that ever be appropriate for a patient to not tell  
19 another provider that he's going to you and getting pain  
20 pills?

21 A. That's not what is in that context or in that  
22 conversation. It's in regards to a test and referral that a  
23 patient needs for medical care.

24 Q. Well, it's a simple question. Did you tell Wendell to  
25 tell the patient, "At no point during any discussion with his

1 primary care prior should he mention us." Did you say that?

2 A. In the context -- as it is on paper right there, but it's  
3 in a specific context.

4 Q. Well, the context is you say it's so it wouldn't mess up  
5 his insurance?

6 A. It would allow him to get the appropriate medial care he  
7 needed and have his insurance cover that care.

8 Q. But don't -- you agreed earlier it was important that  
9 healthcare providers work together and you know what everybody  
10 is doing. So why wouldn't you want him to tell his provider  
11 that he was getting controlled substances from you?

12 A. That's not the context of that conversation. That's a  
13 context of X-rays and the orthopedic referral, which is  
14 specifically so his insurance would be able to be billed and  
15 paid for. Because if I order that X-ray and I refer him to an  
16 orthopedist, his insurance won't cover it because he's an  
17 out-of-state patient and his insurance won't cover --

18 Q. So why don't you tell him to tell his primary care  
19 provider about us but tell him to order it himself?

20 A. I'm not sure why I made that specific distinction, but  
21 the conversation, as far as I can tell, had nothing to do with  
22 controlled substances.

23 MR. RAMSEYER: Thank you.

24 THE COURT: All right. Any further questions?

25 Exhibit 108, is that admitted?

1 MR. RAMSEYER: Was -- 108 was the -- I picked it up.  
2 I'll get it.

3 THE COURT: All right. Mr. Williams, let's not  
4 repeat. All right?

5 MR. WILLIAMS: Okay.

6 **REDIRECT EXAMINATION**

7 BY MR. WILLIAMS:

8 Q. Dr. Smithers, let's talk about Heather Hartshorn for just  
9 a minute. You treated Heather on February the 20th, I  
10 believe, of -- just prior to her death; is that correct?

11 A. That's correct.

12 Q. Okay. And did you have any discussions with Heather  
13 about her medications that day?

14 A. I did, yes, sir.

15 Q. What were those discussions about?

16 MR. RAMSEYER: Your Honor, I think it exceeds the  
17 direct -- or the cross.

18 THE COURT: Yes, sir. I mean, we've been through  
19 his direct examination, Mr. Williams.

20 BY MR. WILLIAMS:

21 Q. Did -- Dr. Smithers, did you have any -- Mr. Ramseyer  
22 talked to you about flushing pills and stuff, that Mr. Wilson  
23 flushed pills. Did you have any concerns over flushing pills?

24 A. I did. I eventually actually did some research, and the  
25 EPA, I believe, was recommending -- some study was

1 recommending that that practice be ceased. When I did the  
2 research on it, there were conflicting opinions at the time,  
3 but that -- that was the most prominent thing in my mind at  
4 the time and that's why I didn't flush all the pills.

5 Q. Okay. Now, with respect to Sharon Mullins, when you met  
6 her at the Starbucks parking lot, why did you meet Sharon  
7 Mullins that day?

8 A. I had a sick child at home, and I myself was actually  
9 quite ill that day and I felt terrible that she had spent the  
10 night in a hotel and that my office wasn't going to be open,  
11 and I didn't know -- I mean, it was kind of an emergency. I  
12 didn't know any other way to proceed. And it was probably an  
13 error in judgment on my part to -- to -- to proceed that way.

14 Q. Now, with -- going back to Heather Hartshorn, on -- did  
15 you mail her any prescriptions?

16 A. If I did, it may have been one time. I don't recall  
17 any --

18 Q. You didn't mail her a prescription the day -- on the --

19 A. Oh, no. No. I saw her in the office. Yes, sir.

20 Q. And you actually physically saw her?

21 A. Yes, sir.

22 Q. Did an examination?

23 A. Yes, sir.

24 Q. How many telemed visits did you have with people,  
25 approximately?

1 A. It varied. It typically only would occur if I was on  
2 vacation or if I was sick. I mean, it -- there was -- I mean,  
3 most weeks it didn't happen. Then there were weeks where, I  
4 mean, there may have been -- you know, we probably typically  
5 saw 7 to 10 patients a day, you know, maybe 30 patients a  
6 week. So you know, if I wasn't there for the whole week --

7 THE COURT: So do you know how many?

8 THE WITNESS: I don't. I don't. Your Honor, I'm  
9 sorry. I'm rambling. Yeah. I don't know a specific number.

10 BY MR. WILLIAMS:

11 Q. Okay. Now, is it a fair statement to say that for the  
12 majority of the time you actually --

13 MR. RAMSEYER: Objection to leading, Your Honor. I  
14 mean, I know we're trying to move things along, but --

15 THE COURT: Yes, sir, I'll sustain the objection.

16 BY MR. WILLIAMS:

17 Q. Percentage-wise, how many times did you actually see the  
18 patient in your office as compared to not?

19 A. Over the amount of time I practiced, I would say maybe  
20 five to ten percent.

21 Q. Five to ten percent that you would do it through  
22 telemedicine --

23 A. Correct.

24 Q. -- or that you wouldn't actually see the patient?

25 A. Correct, yes, sir.



1 MR. WILLIAMS: No further questions, Your Honor.

2 THE COURT: All right. Anything further?

3 MR. RAMSEYER: No, Your Honor.

4 THE COURT: All right. Thank you, sir. You may  
5 step down.

6 All right. Mr. Williams, do you have any further  
7 evidence?

8 MR. WILLIAMS: Your Honor, I think my client has one  
9 other witness that's supposed to be here tomorrow that he had  
10 indicated.

11 THE COURT: All right. And that's the last witness?

12 MR. WILLIAMS: It's -- we actually had two, but I  
13 have not had a chance to contact the second one. That was the  
14 lady from Florida that I've advised the Court about, but I  
15 have not been able to get ahold of her as of yet.

16 THE COURT: All right. Very well.

17 Now, we've ended with the doctor, Mr. Williams. You  
18 understand?

19 MR. WILLIAMS: Yes, Your Honor.

20 THE COURT: All right. Ladies and gentlemen, I'm  
21 sorry I kept you so late, but I think it had benefits. So if  
22 you could return tomorrow so we could begin at 9:00. And  
23 drive carefully, and we'll see you in the morning. If you'll  
24 follow the bailiff out.

25 (Proceedings held in the absence of the jury.)

1           THE COURT: All right. Counsel, is there anything  
2 we need to take up? If not, we'll adjourn court until 9:00 in  
3 the morning.

4           (Proceedings concluded at 5:57 p.m.)  
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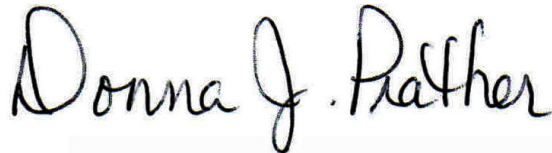
Donna Prather, CCR, RPR, CCP, CCB

Official Court Reporter for the U.S. District Court Western District of Virginia

**REPORTER'S CERTIFICATE**

I, DONNA J. PRATHER, do hereby certify that the above and foregoing, consisting of the preceding 259 pages, constitutes a true and accurate transcript of my stenographic notes and is a full, true and complete transcript of the proceedings to the best of my ability.

Dated this 7th day of June, 2019.

A handwritten signature in black ink that reads "Donna J. Prather". The signature is written in a cursive, flowing style.

DONNA J. PRATHER, RPR, CRR, CBC, CCP  
Federal Official Court Reporter

Donna Prather, CCR, RPR, CCP, CCB

Official Court Reporter for the U.S. District Court Western District of Virginia

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Donna J. Prather

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Donna J. Prather

Donna Prather, CCR, RPR, CCP, CCB

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Donna Prather, CCR, RPR, CCP, CCB

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